S. HRG. 106–582

MENTAL HEALTH PARITY

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

EXAMINING MENTAL HEALTH PARITY ISSUES, INCLUDING S. 796, TO PROVIDE FOR FULL PARITY WITH RESPECT TO HEALTH INSURANCE COVERAGE FOR CERTAIN SEVERE BIOLOGICALLY-BASED MENTAL ILLNESSES AND TO PROHIBIT LIMITS ON THE NUMBER OF MENTAL ILLNESS-RELATED HOSPITAL DAYS AND OUTPATIENT VISITS THAT ARE COVERED FOR ALL MENTAL ILLNESSES

MAY 18, 2000

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CONTENTS

STATEMENTS

MAY 18, 2000

Page

Jeffords, Hon. James M., Chairman, Committee on Health, Education, Labor, and Pensions, opening statement 1
Kennedy, Hon. Edward M., a U.S. Senator from the State of Massachusetts, opening statement 2
Domenici, Hon. Pete V., a U.S. Senator from the State of New Mexico, prepared statement 4
Wellstone, Hon. Paul D., a U.S. Senator from the State of Minnesota, opening statement 5
Prepared statement 7
Allen, Kathryn G., Associate Director, Health Financing and Public Health Issues, U.S. General Accounting Office, Washington, DC; and Dr. Steven E. Hyman, Director, National Institutes of Mental Health, NIH, Bethesda, MD 12
Prepared statements of:
Ms. Allen 14
Dr. Hyman 26

ADDITIONAL MATERIAL

Articles, publications, letters, etc.:
Insurance Parity for Mental Health: Cost, Access, and Quality—Final Report to Congress by the National Advisory Mental Health Council 34

APPENDIX

Dodd, Hon. Christopher J., a U.S. Senator from the State of Connecticut, prepared statement 71
Libertoff, Ken, director, Vermont Association for Mental Health, Montpelier, VT; Dr. Kenneth Duckworth, deputy commissioner, Massachusetts Department of Mental Health, Boston, MA; Tara Wooldridge, manager, employee assistance program, Delta Air Lines, Atlanta, GA; and Dean Rosen, senior vice president of policy and general counsel, Health Insurance Association of America, Washington, DC 79
Prepared statements of:
Mr. Libertoff 83
Dr. Duckworth 89
Ms. Wooldridge 93
Mr. Rosen 99
American Psychological Association, prepared statement 110
National Alliance for the Mentally Ill, the, prepared statement 114
National Depressive and Manic-Depressive Association, prepared statement 119
American Occupational Therapy Association, prepared statement 120

MENTAL HEALTH PARITY

THURSDAY, MAY 18, 2000

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in room SD–430, Dirksen Senate Office Building, Senator Jeffords (chairman of the committee) presiding.

Present: Senators Jeffords, Collins, Kennedy, Dodd, Wellstone, Murray, and Reed.

OPENING STATEMENT OF SENATOR JEFFORDS

The CHAIRMAN. The committee will come to order.

Good morning. Today we are drawn together because we share a common interest in ensuring that Americans have access to quality insurance coverage for mental as well as physical health care.

Research shows that early recognition of mental illness oftentimes reduces the onset of more serious mental illness and more expensive interventions down the road. And recent scientific advances in the development of new psychotropic drugs allow for effective treatment of mental illness.

It was information like this that led Congress to pass the Mental Health Parity Act of 1996, which I supported. Although far from requiring full parity, this landmark measure puts health insurance coverage for mental illness on an equal footing with coverage for physical illness.

However, absent congressional action, these requirements are due to expire on September 30, 2001.

Since the passage of the Federal law, there has been a rapid increase in the number of States that have passed laws providing some level of parity for mental health care. Thirty States can now claim to have taken full or partial steps toward mental health parity. I am proud that my own State of Vermont led the effort early on with its legislation granting full parity for both mental health services and substance abuse services.

In order to understand the Federal law's impact, I have asked the GAO to report on the implementation of the Mental Health Parity Act and its effects on health plans. This report is being released today. It is entitled "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited."

In the report, I asked the GAO to address the following questions: To what extent have employers complied with the law, and how have they revised their plans? What are the law's effects on

claims costs? And what steps have Federal agencies taken to ensure compliance with the law?

Dr. Hyman, the director of the National Institute of Mental Health, has also been invited today to share with us the scientific promise of treatment for mental illness.

The National Mental Health Advisory Council will soon release its new report on how State and Federal parity laws have affected the costs and quality of care. Dr. Hyman is the chairman of that group, so I am sure he will be able to share some of his report findings with us.

However, as this committee examines the details of Federal policy, we must not lose sight of the fundamental goal to reduce the stigma associated with mental illness. Anyone who feels he or she might need treatment must be encouraged to seek it and must feel comfortable in seeking it.

The Mental Health Parity Act has a great impact on the everyday lives of those living with mental illness. I look forward to this hearing, because the committee has demonstrated a clear interest in increasing access to quality mental health care for all Americans.

I would like to thank our witnesses for being here. We are all very sorry that Senator Domenici could not be present; I am sure he wishes he could have been here. Both Senator Domenici and Senator Wellstone have become national leaders on these issues, and we are lucky to have Senator Wellstone with us today to testify.

I now turn to Senator Kennedy, my companion and a great leader in this area.

Senator Kennedy.

Opening Statement of Senator Kennedy

Senator KENNEDY. I thank you, Mr. Chairman. I appreciate your initiatives in this area, your consistency in following what has been happening in the States and also at the national level, and your reminding us of our responsibilities in this area. We have important responsibilities in terms of reauthorization, and we are hopefully reauthorizing based on the lessons that we have learned. We will hear today some excellent testimony which hopefully will be convincing to our colleagues and to the country in terms of supporting important legislation that will address this issue.

I join as well in welcoming our colleagues. Senator Domenici is necessarily absent today. I spoke with him and he has some considerable discomfort. We do regret that he cannot be here since we always look forward to his participation. As you pointed out, Senator Wellstone and Senator Domenici have been very helpful in educating the Senate and the country about our responsibilities in health care in this area.

President Kennedy's 1963 State of the Union Message included the following statement: "I believe that the abandonment of the mentally ill and the mentally retarded to the grim mercy of custodial institutions too often inflicts on them a needless cruelty which this Nation should not endure."

That was nearly 40 years ago, and advances in science since then have enabled us to make great progress in the treatment of mental

illness. But too often today, patients with mental illness are denied state-of-the-art treatment that would be available if their illnesses were physical instead of mental. This unacceptable discrimination is not only wrong, but costly. The total cost of mental illness to the Nation in terms of treatment and lost productivity is about $150 billion a year according to the Surgeon General's report. We pay those costs in the coin of human misery, higher overall medical costs, lost productivity, an overburdened and inadequate system of social services, and prisons and jails overflowing with people who suffer from mental illness.

I want to take a moment to concentrate on how large those costs are and how large the problem is. In this chart, Mr. Chairman, the Surgeon General's report indicates that one in five Americans will experience some form of mental illness this year. Mental illness is our second leading cause of disability.

Yet the success rates for treatment of mental illness are high, as high as 80 percent. This is not necessarily getting a cure, but it indicates important progress where people can function and be effective. It can be as high as 80 percent in bipolar illness, it comes down to almost 65 percent in depression, and the chart shows the lower success rates for hypertension, and diabetes.

We called the 1990's "the Decade of the Brain" and the discoveries of that decade have certainly opened a window to the brain and the mind. As we learn more about the science of mental illness, more and better cures are likely to emerge.

Unfortunately, the majority of people suffering from mental illness go untreated. The first chart showed that mental illness is the second leading disability. The next chart showed the progress that can be made in treating mental illness. This chart shows the inadequacy of our current approach in the delivery of health care—many more people are untreated than are treated. I think it really puts in stark relief the challenge which we face.

Many individuals do not seek treatment due to the fear and stigma of mental illness. Many of the millions of Americans suffering from mental illness do not receive treatment because their treatment will not be covered by insurance or because the copayments are too high.

So it is difficult to convince people to seek treatment if their insurance plans do not cover it. We know that many of the elderly go without prescription drugs because they cannot afford them; many other Americans suffering from mental illness do not seek treatment for the same reason.

As you mentioned, we passed the Mental Health Parity Act of 1996 in an effort to end this cruel and unacceptable discrimination. Many of us had hoped for a much stronger bill which would guarantee full insurance parity for those with mental illness. The Senate took the middle road, hoping that employers and insurance companies would provide such parity. We were wrong. Unfortunately, as we will see today, the promise of real parity for mental health has become an empty one, and the benefits to consumers have been grossly inadequate.

There is a glimmer of hope in some States, including, as you mentioned, Mr. Chairman, your own State of Vermont and my State of Massachusetts. Earlier this month, Massachusetts passed

a law which would provide parity of coverage for certain mental illnesses. It does not cost a great deal to provide full parity and it eliminates enormous costs in human suffering.

We know who these people are who are not receiving treatment today. They are our fellow citizens in communities across the country who have been neglected for far too long. It is long past time to provide genuine parity in our health care system for those suffering from mental illness.

Today's hearing is a significant step in the right direction, and I look forward to the testimony of our witnesses. I want to extend a special welcome to Dr. Duckworth, our Massachusetts witness, who has elected to spend his birthday with us here today.

I also want to join in welcoming our friend and colleague and one of our good leaders in issues of mental health in the Senate, Senator Paul Wellstone.

The CHAIRMAN. Thank you, Senator Kennedy.

As you all know, we had anticipated the attendance of Senator Pete Domenici, the senior Senator from New Mexico, and we will certainly miss having him here. It is well known that these issues are very important to Senator Domenici, both personally and as a matter of policy.

Senator Domenici's full statement has been distributed and will be included in the record, but I would like to take a moment to read a portion of it out loud.

Senator Domenici writes: "I would like to pose a question: What if, 30 years ago, our Nation had decided to exclude heart disease from health insurance coverage? I would submit the Mental Health Parity Act of 1996 is a good first start, but it is also not working. While there may be adherence to the letter of the law, there are violations of the spirit of the law. Consequently, Senator Wellstone and I have again joined forces and introduced the Mental Health Equitable Treatment Act of 1999. The bill seeks a very simple goal: 1) to provide full parity for certain severe, biologically based mental illnesses and 2) to prohibit limits on the number of covered hospital days and outpatient visits for all mental illnesses.

"I am sure that my colleague from Minnesota, Senator Paul Wellstone, will be able to expand upon these remarks. Senator Wellstone is the senior Senator from Minnesota, first elected to the Senate in 1990. He follows a proud tradition of Minnesota Senators who have been strong voices and fighters for those who have no one else to fight for them."

I now turn to Senator Wellstone.

[The prepared statement of Senator Domenici follows:]

PREPARED STATEMENT OF SENATOR PETE V. DOMENICI

Good morning and it is a pleasure to be here before the HELP Committee for this very important hearing. I would especially like to thank Chairman Jeffords for holding this Mental Parity Hearing and requesting the GAO Report being unveiled today.

I would like to begin by posing a question: what if thirty years ago our nation had decided to exclude heart disease from health *insurance coverage?

Think about some of the wonderful things we would not be doing today like angioplasty, bypasses, and valve replacements AND the millions of people helped because insurance covers these procedures.

But today, all too often insurance discriminates against those suffering from a mental illness. The human brain is the organ of the mind and just like the other

organs of our body, it is subject to illness. And just as illnesses to our other organs require treatment, so too do illnesses of the brain.

Even though we know so much more about mental illness, it can still bring devastating consequences to those it touches; their families, their friends, and their loved ones. Medical science is in an era where we can accurately diagnosis mental illnesses and treat those afflicted so they can be productive.

Let us also look at the efficacy of treatment for individuals suffering from certain mental illnesses. Treatment for bipolar disorders has an 80 percent success rate. Schizophrenia, the most dreaded of mental illnesses, has a 60 percent success rate in the United States today if treated properly. Major depression has a 65 percent success rate.

I would ask then, why with this evidence would we not cover these individuals and treat their illnesses like any other disease? We should not. Moreover, we have before us a report from the GAO that further bolsters this argument.

GAO found the costs associated with the Federal Parity law have been negligible for most health plans. In fact, only 3 percent of employers reported an increase in costs. Consumers in States without more comprehensive parity laws have only seen minor changes in their mental health benefits. Two thirds of the plans complying with the Federal parity law have lower mental health hospital day and outpatient office visit limits than medical and surgical benefits.

Thus, I would submit the Mental Health Parity Act of 1996 is good first start, but it is also not working. While there may be adherence to the letter of the law, there are violations of the spirit of the law.

For instance, ways are being found around the law by placing limits on the number of covered hospital days and outpatient visits.

Consequently, Senator Wellstone and I have again joined forces and introduced the Mental Health Equitable Treatment Act of 1999. The Bill seeks a very simple goal: 1) provide full parity for certain severe biologically based mental illnesses and 2) prohibit limits on the number of covered hospital days and outpatient visits for all mental illnesses.

I think it also worth mentioning that there is a definite trend at the State level to pass mental health parity legislation. Thirty States now have mental health parity laws. In fact, I had the opportunity to attend the signing ceremony of New Mexico's Mental Health Parity law just a couple of months ago.

Thank you and I look forward to working with my colleagues on this important issue.

Opening Statement of Hon. Paul D. Wellstone

Senator WELLSTONE. Thank you, Mr. Chairman.

It is an honor to serve on this committee with my colleagues.

First of all, I regret the fact that Senator Domenici cannot be with us. I talked with him yesterday, and I know he was anxious to be here. He has really been struggling with a very severe problem in his neck and has been in a lot of pain, and you can see that in his face. And believe me, he would be here if he could be here.

I would like to thank Pete Domenici, and I would like to thank Nancy Domenici for their leadership. And I would like to thank all of my colleagues on the committee for their interest.

Mr. Chairman, I want to be a part of this hearing, and I want to listen to the other witnesses, so I think I will be relatively brief and ask consent that my full statement be included in the record.

The CHAIRMAN. It will be included.

Senator WELLSTONE. Thank you.

Let me thank you for this opportunity to speak to the committee on an extremely critical health issue affecting millions of Americans—parity for the treatment of mental illness.

I think everybody on this committee, and really, I think everybody whom I have ever met, can point to a loved one or a friend who has struggled with mental illness, and I think the field of mental health is becoming more and more important. But as Senator Kennedy pointed out, on the one hand, we know that so much

of mental illness is diagnosable and treatable, but on the other hand, quite often because of discrimination or because of lack of coverage, we do not get the treatment to people.

Kay Jamison, whose work I am so persuaded by, is a psychiatrist at Johns Hopkins who has written several really important books. She has tried to take her own life more than once, and she has written about her own struggle, so she is both a professional, and someone who has struggled with this illness. She said at a hearing that the gap between what we know and what we do is lethal, and that is the way that I feel about it.

Senator Domenici mentioned the Mental Health Equitable Treatment Act, which I want to talk about, because having the chance to talk about it before this committee is a critical step forward for us in trying to pass this legislation. To go to what Senator Kennedy said, when we passed the parity bill, which was partial parity, in the summer of 1996, we viewed it kind of as a small step forward. I thought, frankly, how it was won was almost more important than what was won, because you had so many people who had been struggling with this illness coming to Washington and talking to Senators and, really, no longer accepting the stigma and the discrimination and no longer willing to be viewed as second-class citizens. To me, that was really the key thing, and this was to be a step in the right direction.

But as Senator Kennedy pointed out, and Robert Pear points out in today's New York Times, there are two problems, to summarize—noncompliance in balance of letter and spirit. In the letter part, all too many companies are simply not even complying with the law, which is unbelievable. But the other thing, Senator Kennedy, is that there is just too big a loophole. The problem is that all too many companies have just raised the copayments and the deductibles so high, and have put such severe restrictions on days in the hospital and physician visits that, basically, people are denied treatment. That is the real problem, so that nobody ever gets to the question of making sure there is parity on annual or lifetime limits, because they do not get the coverage in the first place.

The most important thing about the Mental Health Equitable Treatment Act, Mr. Chairman, that we have introduced—and I think we now have 28 cosponsors, including seven Republicans—is that what we have said in this bill is that we have full parity for hospital days and physician visits. You just cannot treat someone who is struggling with depression any differently than you treat someone who is struggling with Parkinson's disease. The bill also has a broad range of adult and childhood illnesses where there is parity in copayment and deductible benefits.

In the best of all worlds—and some of you will smile hearing me say this—I would have full parity, period. But I view this piece of legislation as a compromise. I want to get it passed. I think it would not be a step sideways, and certainly not a step backward, but a giant step forward. It is not everything, it is not perfect, but just the full parity for the days in the hospital and the physician visits for all mental illnesses, and covering a broad range of adult and childhood illnesses for other benefits would be a giant step forward. I really hope that all of my colleagues on this committee will

help us pass this bill. I know that Senator Kennedy has been a supporter from the beginning, as well as other committee members.

Mr. Chairman, let me just say—I think I will actually set aside the rest of my formal remarks, because I do not really think it goes beyond what I have just said. All of these talking points are great—thank you, Ellen Gerrity; they are terrific—but I actually think I have covered it—in my not-so-humble opinion, I think I have covered the most important points.

The final point is just to go back to—and Dr. Steve Hyman will talk about this, and he has done such a great job as director of the NIMH—Kay Jamison's point again. The thing that gets to me the most is the gap between the knowledge and the treatment. There is a wonderful organization in Minnesota called SAVE, started by Al and Mary Kluesner who, Senator Collins, lost two children who took their lives, and two of their remaining children are very, very successful. Initially, I think they felt all the stigma—such as, what did we do wrong as parents? "Was it our fault?"

Then, parents started talking to parents, and brothers started talking to sisters, and people realized that this is certainly not the moral failing of our loved ones who took their lives, and it is not our moral failing.

We know that with children, it is a huge problem. In my State of Minnesota, for children between the ages of 15 and 25, suicide is the second leading killer. In our State, three times as many citizens lose their lives by suicide by homicide—and yet we do not get the treatment to people.

So I would just say once more that the science is there, the data is there, the studies are there, the knowledge is there. But do you know what is also still there?—the stigma and the discrimination. And the best part is that a lot of great organizations have stepped forward and said "We are not going to accept it any longer," and they are here to push hard for this, and I hope that all of you and other Senators will help Senator Domenici and me pass this legislation.

My last point is that, to be perfectly honest, this is really important, but this legislation and this hearing is all about parity, but it is essentially about those people who have at least some coverage. The legislation states that when you have coverage for mental illness, the insurance companies must establish the same coverage for people who are struggling with mental illness as with physical illness. It still begs the question about all the people with no coverage. They do not get the benefit of any of this legislation. That is yet another big gap.

I hope that on the basis of this fine study—and we will hear from GAO—that we will really take seriously moving this bill forward. Senator Domenici and I are committed to bringing this bill to the floor and passing this legislation. It is time to pass this legislation.

Thank you.

[The prepared statement of Senator Wellstone follows:]

PREPARED STATEMENT OF SENATOR WELLSTONE

Mr. Chairman, I want to thank you for the opportunity to speak to the committee this morning on an extremely critical health issue

facing millions of Americans—parity for the treatment of mental illness.

Last April, along with Senator Domenici, I introduced legislation, the Mental Health Equitable Treatment Act (MHETA, S. 796) that will help ensure that private health insurance companies provide the same level of coverage for mental illness as they do for other diseases. This bill will be a major step toward ending the persistent discrimination against people who suffer from mental illness. Today, you will hear powerful testimony about how badly this treatment coverage is needed, how mental illness has affected the lives of so many Americans throughout our country, and how the costs for such treatment are very low.

For too long, mental illness has been stigmatized, or viewed as a character flaw, rather than as the serious disease that it is. A cloak of secrecy has surrounded this disease, and people with mental illness are often ashamed and afraid to seek treatment, for fear that they will be seen as admitting a weakness in character. We have all seen portrayals of mentally ill people as somehow different, as dangerous, or as frightening. Such stereotypes only reinforce the biases against people with mental illness. Can you imagine this type of portrayal of someone who has cancer, heart disease, or diabetes?

Although mental health research has made many advances in establishing the biological, genetic, and behavioral components of many of the forms of serious mental illness, the illness is still stigmatized as somehow less important or serious than other illnesses. Too often, we try to push the problem away, deny coverage, or blame those with the illness for having the illness. We forget that someone with mental illness can look just like the person who is sitting next to us on a plane or working with us in our office. It can be our brother, our daughter, our father, our mother, our friend. It can be ourselves. We have all known someone with a serious mental illness, within our families or our circle of friends, or in public life. Many people have courageously come forward to speak about their personal experiences with their illness, to help us all understand better the effects of this illness on a person's life, and I commend them for their courage.

The statistics concerning mental illness, and the state of health care coverage for adults and children with this disease are startling, and disturbing. The current estimate is that about 20 percent of the U.S. adult population are affected by mental disorders during a given year, and although the research on children is not as well-documented, the percentage of children affected by mental or emotional disorders appears to be very similar, at 20 percent, with 9 percent severely affected.

One severe mental illness affecting millions of Americans is major depression. The National Institute of Mental Health, a NIH research institute within the U.S. Department of Health and Human Services, describes serious depression as a critical public health problem. More than 18 million people in the United States will suffer from a depressive illness this year, and many will be unnecessarily incapacitated for weeks or months, because their illness goes untreated. Depressive disorders are not the normal ups and downs everyone experiences. They are not just "the blues." They

are illnesses that affect mood, body, behavior, and mind. Depressive disorders interfere with individual and family functioning. Without treatment, the person with a depressive disorder is often unable to fulfill the responsibilities of spouse or parent, worker or employer, friend or neighbor. Without treatment, a person can die.

Available medications and psychological treatments, alone or in combination, can help 80 percent of those with depression. But without adequate treatment, future episodes of depression may continue or worsen in severity. Yet, the steady decline in the quality and breadth of health care coverage is truly disturbing.

We know from the recent Surgeon General's Report on Mental Health that the costs of mental illness in our country are very high. The direct costs of mental health services (i.e., spending for treatment and rehabilitation) in the United States in 1996 totaled $69.0 billion. This figure represents 7.3 percent of total health spending. We know too that when economists calculate the costs of an illness, they also strive ' to identify indirect costs, such as lost productivity at the workplace, school, and home due to premature death or disability. The 1990 indirect costs of mental illness were estimated in the Surgeon General's Report to be $78.6 billion. The suffering of people with mental illness and their families because of broken lives, broken dreams, and the financial devastation that can result is immeasurable.

The results of a major survey of employer-provided health plans was published in 1998 by the Hay Group, an independent benefits consulting firm. The Hay Report showed a major decline in benefits in the last decade. Employer-provided mental health benefits decreased 54 percent and the number of plans restricting hospitalization for mental disorders increased by 20 percent. Descriptions of benefit limits themselves are often misleading. Although some plans may say that they allow 30 days for hospitalization, this is rarely approved. In 1996, the average length of stay was 8½ days, down from 17 in 1991. In 1988, most insurance plans allowed 50 therapy sessions per year. In 1997, the average number was 20. Clearly, people with mental illness are having fewer and fewer opportunities to receive appropriate medical care.

Opponents of mental health parity often mention cost. No one, of course, expects coverage of any illness to cost nothing. But what we do know is that fears of spiraling costs for mental health treatment are unfounded. Recent studies from HHS that have examined the effects of mental health and substance abuse treatment parity have shown that full parity for these benefits would be just slightly higher than current premiums. Most reports, like the one requested by Congress from the National Advisory Mental Health Counsel, showed that when mental health coverage is managed, either moderately or tightly, premium increases can be as low as 1 percent.

These costs are so low. And the cost of NOT treating is so high—especially when one looks at the toll that untreated mental illness takes on individuals, families, employers, corporations, social service systems, and criminal justice systems. I have seen firsthand in the juvenile corrections system what happens when mental illness is criminalized, when youth with mental illness are incarcerated for exhibiting symptoms of their illness. To treat ill people as crimi-

nals is outrageous and immoral. We must make treatment for this illness as available and as routine as treatment for any other disease. The discrimination must stop.

Our bill includes parity for hospital day and outpatient visits for all mental illnesses. Additionally, for many of the most severe adult and child mental illnesses, the bill establishes full parity, i.e., parity for copayments, deductibles, hospital day, and outpatient visit benefits. I believed it was particularly important that for the illnesses covered through this benefit that we include as many childhood illnesses as we could. The bill also provides protection for nonphysician providers, and for states with stronger parity bills; includes a small business exemption, and eliminates the sunset provision and the 1 percent exemption from the 1996 Mental Health Parity Act. Covered services include inpatient treatment; non-hospital residential treatment; outpatient treatment, including screening and assessment, medication management, individual, group and family counseling; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for mental illness.

The Mental Health Equitable Treatment Act of 1999 provides for major improvements in coverage for mental illness by private health insurers. It does not require that mental health benefits be part of a health benefits package, but establishes a requirement for parity in coverage for those plans that offer mental health benefits. This bill goes a long way toward our bipartisan goal: that mental illness be treated like any other disease in health care coverage. We know from the GAO study released today that this new law is absolutely necessary. The study shows that employers freely acknowledge that they have taken many steps to further restrict access to mental health treatment, either through limitations on services or by increasing cost-sharing.

The movement for parity for treatment for mental illness is growing. Over the past few years, the principle of parity in insurance coverage for mental health treatment has received the strong support of the White House and the Surgeon General, and many leading figures in medicine, business, government, journalism, and entertainment who have suffered from mental illness and have been successfully treated. Federal employees will soon be entitled to full mental health and substance abuse treatment parity. The mental health legislation on the Hill has frequently highlighted the recent major advances in scientific information about the disease; the biological causes or consequences of mental illness; the effectiveness and low cost of treatment; and many painful, personal stories of people, including children, who have been denied treatment. In addition to Federal parity legislation, 31 of our States have passed some form of mental health or substance abuse treatment parity. We do not discriminate against other illnesses where the brain is affected; why do we continue to discriminate against mental illness? It is time for the federal government to enact legislation that will help move us toward full parity for mental illness.

The important thing to remember is that we cannot wait any longer for mental health treatment parity in our country. Mental illness is a real illness, and to fail to provide treatment for those suffering from this disease is costly and life-threatening. We need

to do more to help. This hearing today is an important step to making sure we change the laws, the attitudes, and the practices in our society that lead to this discrimination. But it is only a modest first step. The 1996 Mental Health Parity law was a groundbreaking Federal law that sent the message loud and clear that we will not tolerate the exclusion of those with mental illness from our health care system. A critical next step is enactment this year of this new bill, the Mental Health Equitable Treatment Act of 1999, which is designed to take an even larger step toward ending the suffering of those with mental illness who have been unfairly discriminated against in their health coverage. I hope the Senate will move forward quickly on this bill, and get it enacted into law before the end of this Congress.

The CHAIRMAN. Thank you, Senator Wellstone, for a very passionate and well-reasoned statement.

Senator KENNEDY. If I could just address one point, Mr. Chairman.

The CHAIRMAN. Certainly.

Senator KENNEDY. We are constantly reminded of the costs of mental health coverage. Could you just comment on the other costs of not doing this. We used to formulate policy based on the inherent benefits in terms of the individual, and I know that is your primary motive, but we also have to be conscious of cost. However, we really do not give a lot of focus and attention to the costs of not doing this.

We are going to hear later from Delta Airlines, and they make a judgment that this is sound economics in terms of business to provide full benefits. What they are doing in their program is very interesting. I would be interested in their response as to how they can provide these benefits and still be able to compete, because what we often hear from the business community is that we cannot do this because our competitors do not do it, and therefore, we are not going to do it. Yet we have an airline, Delta, that is providing very comprehensive coverage because they think it is good business.

I know you cannot give us exact figures, but could you make a general observation in terms of reminding the country about what we are paying in terms of broken lives—whether it is prison and jail or whether it is lost productivity? Don't you believe that far outweighs what it would cost in terms of providing the necessary coverage to people? Could you just quickly comment on that, and then we will move on.

Senator WELLSTONE. I was with you until you said "quickly." [Laughter.]

Senator KENNEDY. That is why I said it. [Laughter.]

Senator WELLSTONE. I know why you said it——

First, I will commend all my colleagues who are here. The Surgeon General's report does an excellent job of addressing the costs. To paraphrase and to put it in personal terms, you have the cost of people who are not able to be productive at work and, therefore, the cost to the private sector and the public sector; you have the cost of children not doing well in school, dropping out, and then the relationship between high school dropouts and all the other problems that we see; you have the cost of families who are not able

to make it and all the problems which then exist and all the ways in which we have to deal with those problems.

The list goes on and on, but the point is that there is a far higher cost of not acting than of acting. And finally—I will say it one more time; maybe I was not explicit enough—you have the cost of not only broken dreams and broken lives and broken families, but of loss of life. There are far too many citizens—and I will start with children again—who do not get any kind of treatment—we do not do the diagnosis, and we do not do the treatment—who are struggling with depression and who take their lives. This is the cost of lives that are lost.

So I think surely we can do much better. Thank you.

Senator KENNEDY. Thank you very much.

The CHAIRMAN. Thank you. And we welcome your joining us on the panel.

I would like to welcome our second panel of witnesses now.

First, I am very pleased to introduce Ms. Kathryn G. Allen, associate director for Health Financing and Public Health Issues at the U.S. General Accounting Office in Washington. Ms. Allen directs GAO's work on matters of private health insurance, Medicaid, the State Children's Health Insurance Program, SCHIP, and long-term care. Having spent 24 years at GAO, Ms. Allen has directed evaluations concerning, among other things, Medicaid managed care quality, access for high-risk populations, quality of care in nursing homes, and health insurance coverage for people who qualify for both Medicare and Medicaid.

Ms. Allen, thank you very much for being here, and welcome. I will introduce Dr. Hyman when you have concluded your testimony.

STATEMENTS OF KATHRYN G. ALLEN, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC; AND DR. STEVEN E. HYMAN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, NIH, BETHESDA, MD

Ms. ALLEN. Thank you, Mr. Chairman, Senator Kennedy, and other members of the committee.

We are pleased to be here today as you consider reauthorization of the Mental Health Parity Act of 1996. As we all well know, the Act is intended to help address disparities in coverage between mental health and other illnesses and most employer-based group health insurance programs—that is, those with more than 50 employees.

Specifically, the Act prohibited employers from imposing dollar limits on mental health coverage that are more restrictive than limits imposed on medical/surgical coverage.

In preparing for this first oversight hearing on the Act, as you acknowledged earlier, you asked that we gather information on three issues—employers' responses to the law to comply with its provisions; the associated effects on employers' health insurance claims costs; and steps that Federal agencies are taking to ensure compliance with the law.

We have prepared a report on our findings, and it is being released today for this hearing. My comments today will summarize our key findings.

I would like to start by saying that our findings are largely based on a survey that we conducted of affected employers in 27 States, including the District of Columbia, that have laws that do not exceed the requirements of the Act. Almost 900 employers responded to that survey.

Our first finding is that the majority of respondents that we surveyed, 86 percent, reported that they are complying with the Federal parity law as written by having annual and lifetime dollar limits that are at least as generous for mental health as for other medical and surgical benefits. This is a notable increase from a 55 percent rate in 1996, before the law was enacted.

However, many employers have made offsetting changes in their coverage of mental health benefits that introduce provisions other than dollar limits that are more restrictive for mental health than for other health benefits. These restrictions most often limit the number of hospital days and outpatient visits for mental health treatment. In fact, two-thirds of the employers who changed their annual and lifetime dollar limits to comply with the Act also placed at least one tighter restriction on these other benefits. In contrast, only one-fourth of employers who had to make no changes to comply with the law added such restrictions.

As for employers' claims costs, the Federal parity law we found appears to have had a very negligible effect. In fact, only 30 percent of responding employers reported that compliance with the law has increased their claims cost, and virtually no employer—only five in our entire survey—indicated that they had dropped mental health benefits or health coverage altogether. And only one of those attributed it to the Act itself.

Two factors help explain these minimal cost effects. First, as already mentioned, is the decision by many employers to impose other restrictions on mental health benefits which can make the dollar limits irrelevant, as Senator Wellstone has also pointed out. And second is the prevalence of managed care in employer-sponsored plans, which uses varying strategies to coordinate and control the use of mental health services as well as cost.

But even in States that have enacted parity laws more comprehensive than the Federal law, the resulting cost increases are expected to be very modest—in fact, only 2 to 4 percent.

With regard to the last area that you asked us to examine, we have reviewed what the Department of Labor and the Health Care Financing Administration have done or plan to do. These agencies have made varying progress in performing their roles under the law. The Department of Labor is expanding what it has traditionally done to oversee private, employer-sponsored benefit plans, especially those self-funded plans that are not regulated by the States. Traditionally, the Department has relied upon a complaint-driven approach which investigates situations where it has received a complaint. The Department has begun a strategy of pilot investigations in which it has already randomly selected about 200 employers to gauge their overall compliance with parity and other Federal standards.

The Health Care Finance Administration, which is required to step in where States do not enforce requirements on insurance carriers, is still in the process of fully determining the nature and extent of its oversight responsibilities. But at present, HCFA has identified three States that appear not to have laws that conform to the Federal law and is at the same time still evaluating whether laws in 24 other States fully conform to the Federal standards.

In conclusion, Mr. Chairman, our work indicates widespread self-reported compliance with the Act on the part of affected employers, with negligible effect on their cost. But this has been achieved in large measure by the frequent addition of provisions that restrict mental health benefits in other ways. Further, a significant minority of employers—a minority, but still 14 percent—that represent as many as 13,000 employers admittedly continue to offer lower mental health coverage in direct contradiction of the law.

As the Congress considers proposals to reauthorize the Act or even to expand it, it is instructive to consider these employer responses but also to consider the experience of the 29 States that have enacted parity laws more comprehensive than the Federal law. These more comprehensive State laws which require parity not only in dollar limits but also in service limits, cost-sharing or both, as in the State of Vermont and others, may provide insight into the potential costs of extending parity, which are estimated to be modest.

Another dynamic, of course, is the evolving role of managed care and its influence on cost as well as access to appropriate services. Other witnesses today will undoubtedly be able to speak more directly and with direct experience in their own States as well as with their employees.

Mr. Chairman, this concludes my prepared remarks.

The CHAIRMAN. Thank you. That is very, very helpful information.

[The prepared statement of Ms. Allen follows:]

PREPARED STATEMENT OF KATHRYN G. ALLEN

Mr. Chairman and members of the committee: We are pleased to be here today to discuss the implementation of the Mental Health Parity Act of 1996. An estimated 40 million American adults suffer from some type of mental illness each year. Private health insurance plans typically provide levels of coverage for the treatment of mental illness that are lower than coverage levels for the treatment of other illnesses. Consequently, patients with severe mental illness can exhaust their mental health coverage before they are fully treated. As you know, the Mental Health Parity Act of 1996 helps address the discrepancies in coverage between mental health and other illnesses by establishing a new federal standard for mental health coverage offered under most employer-sponsored group health plans. Specifically, the law requires parity in dollar limits by prohibiting employers from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than limits imposed on all medical and surgical coverage. Without legislative action, the federal law will sunset on September 30, 2001.

We recently issued a report, prepared at your request, examining the implementation and effects to date of the federal parity law.[1] My remarks today will focus on our findings concerning (1) employers' compliance with the law and the changes they have made to their health benefit plans, (2) what is known about the costs of complying with the law, and (3) the oversight roles of the Department of Health and Human Services (HHS) and the Department of Labor (DOL) in enforcing this law.

[1] The Mental Health Parity Act of 1996, P.L. 104–204, title VII, 110 Stat. 2847, 2944–50 (to be classified at 29 U.S.C. 1185a and 42 U.S.C. 300gg-5).

In brief, we found that most-but not all-employers we surveyed reported that they comply with the law by having parity in mental health and medical and surgical annual and lifetime dollar limits. Among the 863 employers responding to our survey that offered mental health benefits in the 26 states and the District of Columbia with laws no more comprehensive than the federal law, the percentage reporting parity in dollar limits grew from 55 percent in 1996 (before the law was effective) to 86 percent in 1999. However, most of these newly compliant employers reported that they also made changes to make their plans more restrictive in the number of hospital days or outpatient visits covered for mental health than for other medical and surgical benefits. Very few employers reported that the law resulted in higher claims costs. Finally, the Mental Health Parity Act and other recent federal health insurance standards have expanded DOL's role in regulating health benefits and have created a regulatory role for HHS' Health Care Financing Administration (HCFA) that entails federal enforcement of the law when states do not adopt conforming insurance regulations. While HCFA has begun to review state conformance, it has not completely determined the full extent of its required oversight role or specific time periods for making this determination.

BACKGROUND

Private employer-sponsored health insurance plans typically provide lower levels of coverage for the treatment of mental illness than for the treatment of other illnesses. Issuers of coverage-employers that fund their own health plans and health insurance carriers-often limit mental health coverage through plan design features that can be more restrictive for mental health benefits than for medical and surgical benefits. Commonly found are lower service limits for mental health benefits such as the number of covered hospital days or outpatient office visits and higher cost-sharing features for mental health benefits such as deductibles or copayments.

Issuers limit mental health coverage primarily because of their concern about the high costs associated with long-term, intensive psychotherapy and extended hospital stays. An issuer may also restrict mental health benefits to protect itself from adverse selection. That is, a plan with relatively generous mental health benefits may be more likely to attract a disproportionate number of individuals who have high demands for mental health care services, thus driving up the claims and premium costs of the plan.

The Mental Health Parity Act of 1996 amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to require that employer-sponsored health plans have annual and lifetime dollar limits for mental health coverage that are no more restrictive than those for all medical and surgical coverage. The law does not apply to

- plans sponsored by an employer with 50 or fewer employees,
- group plans that experience an increase in plan claims costs of at least 1 percent because of compliance, or
- coverage sold in the individual (nongroup) market.

Furthermore, the law does not require any plan to offer mental health coverage, excludes substance abuse treatment, and does not prevent a plan from imposing more restrictive service limits (hospital days or outpatient visits) or higher cost-sharing requirements on mental health coverage than on medical and surgical coverage. The law became effective for group health plans for plan years beginning on or after January 1, 1998.

Within the past decade, most states also passed laws regulating mental health benefits. As of March 2000, the National Conference of State Legislatures' (NCSL) Health Policy Tracking Service reported that 43 states and the District of Columbia had laws in effect addressing mental health benefits in employer-sponsored group health plans.[2] Twenty-nine states have laws that are more comprehensive than the federal parity law and require parity not only in dollar limits but also in service limits or cost-sharing provisions. Sixteen of these states require full parity. That is, they mandate that mental health coverage be included in all group plans sold, and they require parity in all respects, including dollar limits, service limits, and cost sharing. Laws in six states essentially parallel the federal law by only requiring parity for annual and lifetime dollar limits and not requiring parity in services or cost sharing provisions. Laws in eight states and the District of Columbia are more limited and might not conform to the federal law, and seven states have no laws addressing mental health benefits. Appendix I compares state laws addressing mental health benefits with the federal Mental Health Parity Act.

Enforcement authority for the Mental Health Parity Act is divided between federal agencies and the states. DOL is responsible for ensuring that private employer-

[2] A smaller number of state laws also apply to coverage sold in the individual insurance market.

sponsored group health plans comply with the law-an extension of DOL's regulatory role under ERISA.[3] In states that do not adopt and enforce statutes or regulations that meet or exceed the federal parity standards, HCFA is responsible for directly enforcing the federal insurance standards on carriers. In states that have standards conforming to the federal parity law, state insurance regulators have primary enforcement authority over insurance carriers.[4]

To determine employers' responses to the law, we surveyed 1,656 employers subject to the law, which statistically represented 103,000 employers in the District of Columbia and 26 states. We obtained a response rate of 52 percent. Because our goal was to measure the effect of federal rather than state parity requirements, we surveyed employers with more than 50 employees in the 26 states and the District of Columbia that did not have state laws that were more comprehensive than the federal law as of July 1999.[5] To identify actions the federal agencies have taken to ensure compliance with the law, we interviewed officials from HCFA and DOL's Pension and Welfare Benefits Administration.

MOST EMPLOYERS REPORT COMPLIANCE WITH THE FEDERAL LAW BUT CONTINUE TO LIMIT MENTAL HEALTH BENEFITS

Employers we surveyed reported that they are largely complying with the federal mental health parity law. Eighty-six percent of the employers responding to our survey reported complying with the federal parity requirement, as of December 1999, representing about 68,000 to 74,000 employers in the 26 states and the District of Columbia. However, 14 percent reported that they were noncompliant, representing about 9,000 to 13,000 employers. Both HCFA and DOL officials found the 14 percent noncompliance rate comparable to their own assessments. For example, DOL recently determined from a preliminary review of about 200 employers' health plans it investigated that 12 percent were out of compliance with federal parity standards.

The law has resulted in more employers reporting parity in dollar limits for mental health and medical and surgical benefits. In 1996, before the federal parity law was enacted, only about 55 percent of employers we surveyed reported parity in the annual and lifetime dollar limits for mental health and medical and surgical benefits.[6] When employers were asked why they changed their annual or lifetime dollar limits, more than 75 percent of those responding cited the federal Mental Health Parity Act as a significant or primary reason. Among the employer plans in our survey that were not in compliance with the federal parity law, most had lifetime limits for mental health coverage of $100,000 or less.

Most employer plans we surveyed contained other plan design features that were more restrictive for mental health than for medical and surgical benefits. Typically, these features included limits on the number of covered hospital days and outpatient office visits as well as higher cost sharing such as copayments and coinsurance. As of December 1999, 87 percent of compliant employer plans contained at least one more restrictive provision for mental health benefits.[7] Most prevalent were restrictions on the number of outpatient office visits and hospital day limits, with nearly two-thirds of compliant employer plans having lower limits for mental health than for medical and surgical benefits. Very few employers we surveyed im-

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[3] ERISA allows employers to offer uniform national health benefits by preempting states from directly regulating employer-sponsored benefit plans. As a result, states are unable to directly regulate self-funded plans but can regulate health insurers. Under ERISA, DOL is responsible for ensuring that employer sponsored group health plans meet certain fiduciary, reporting, disclosure, and appeals requirements related to the provision of health benefits.

[4] This federal and state regulatory scheme applies to other federal health insurance standards, including those established under the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998.

[5] GAO/HEHS-00-95 contains further details of our survey and the limitations of our data. Our survey population included all 21 states and the District of Columbia that had no law, a law more limited than the federal law, or a law that meets the federal law based on our review of data that NCSL provided (see app. I). We also surveyed employers in five states identified as exceeding the federal law because (1) two states implemented more comprehensive laws after we selected our sample, (2) two states mandate that mental health benefits be included in most coverage sold but otherwise mirror the federal parity law by requiring parity only in dollar limits, and (3) one state had unclear statutory language and was included by HCFA in its initial determination that the state may not be enforcing the minimum federal standards.

[6] Because of respondent uncertainty and item nonresponse, we could not determine parity for 51 percent of employers in 1996. We were less likely to determine parity for both small employers (51 to 100 employees) and those in the South compared with employers of other sizes and in other areas of the country.

[7] As of December 1999, noncompliant plans did not differ significantly from compliant plans, with about 93 percent of noncompliant plans also containing at least one such restriction.

posed any limits on office visits or hospital days for nonmental health conditions—about 8 and 10 percent, respectively.

Many employers in the states we surveyed changed mental health benefit design features specifically to mitigate the more generous annual and lifetime dollar limits required by the Mental Health Parity Act. About 65 percent of employers that changed annual or lifetime dollar limits after 1996 to be no less restrictive than dollar limits for medical and surgical coverage also changed at least one other mental health design feature to a more restrictive one. Most commonly changed were outpatient office visit limits and hospital day limits, as shown in table 1. Only 26 percent of employers that did not change dollar limits after 1996—that is, plans that were already in compliance or that remained out of compliance—changed at least one mental health design feature to something more restrictive.

Table 1: Employer Plans That Have Added Restrictive Mental Health Benefits Provisions Since 1996

Change	Employers newly compliant with parity requirement	Other employers[a]
Fewer office visits covered	51%	11%
Fewer hospital days covered	36	11
Increased outpatient office visit copayments[b]	20	13
Increased outpatient office visit coinsurance	11	3
Increased cap on enrollee out-of-pocket costs	18	7
Increased hospital stay coinsurance	7	2
Increased hospital stay copayments[b]	3	7

[a]Includes employer plans that already had parity in 1996 and those that did not have parity in 1996 and remained out of compliance in 1999.

[b]The differences in the percentage of newly compliant and other employers that have increased hospital stay and office visit copayments since 1996 are not statistically significant.

Source: GAO survey of employers' mental health benefits.

MOST EMPLOYERS ARE NOT AWARE OF THE LAWS EFFECT ON CLAIMS COSTS, WHICH APPEARS TO BE NEGLIGIBLE

About 60 percent of the responding employers did not know whether compliance with the Mental Health Parity Act increased their plans' claims costs, and about 37 percent reported that compliance had not raised their claims costs. Only about 3 percent of the respondents reported that claims costs rose as a result of the act.[8] However, as noted above, compliance with the act was associated with a greater number of other restrictive provisions for other plan features, such as office visit or hospital day limits, which may have limited the extent to which claims costs would rise. Also, some employer sponsored plans have increased their use of managed care techniques to better coordinate and control the use of mental health services. Moreover, less than I percent of responding employers have actually dropped coverage of mental health benefits or their health benefits plan altogether since the law was enacted, and most cited business reasons other than the cost of implementing the act's requirements for dropping coverage.

Studies aimed at predicting the costs of the federal parity law generally corroborate our finding that requiring parity only in dollar limits resulted in cost increases of less than I percent. For example, in 1996, the Congressional Budget Office estimated that the Mental Health Parity Act would result in claims cost increases of 0.16 percent, and Coopers and Lybrand predicted that claims costs would rise by about 0.12 percent.[9] We are not aware of any additional studies after 1996 that have quantified the change in costs resulting from the federal parity requirements.

[8]The act allows an exemption for group plans that experience an increase in health benefit costs of I percent or more because of compliance with the law's requirements. Federal agencies estimated that as many as 10 percent of health plans affected by the law, or 30,000 health plans, could be eligible for the exemption. However, as of March 2000, DOL officials reported that only nine employers nationally had claimed an exemption.

[9]Coopers and Lybrand, An Actuarial Analysis of S.203 1. "The Mental Health Parily Act of 1996" (n.p.: Sept. 1996).

Most states (29) have enacted mental health laws that are more comprehensive than the federal Mental Health Parity Act and that are thus likely to have a greater effect on claims costs (see app. 1). Unlike the federal law, these laws require parity not only in dollar limits but also in service limits, cost-sharing provisions, or both. In addition, many state laws mandate the inclusion of mental health benefits in fully insured group health plans and cover substance abuse and chemical dependency. Public and private health policy researchers have examined the estimated or actual costs resulting from more comprehensive state parity laws. In addition to estimating increased claims costs in several states, several studies have examined the potential premium cost increases associated with full parity nationally. Most of these studies have estimated the cost increase for full parity in individual states and nationally to be between 2 and 4 percent. These estimates represent a composite of the cost increases for fee-for-service, preferred provider organization, point-of-service, and health maintenance organization (HMO) plans. Typically, estimates assume that HMO and other managed care plans will have lower cost increases than fee-for-service plans.

FEDERAL AGENCIES HAVE MADE VARYING PROGRESS IN OVERSEEING THE PARITY LAW

DOL has traditionally relied on a complaint-driven approach to identify noncompliance with federal health plan standards. However, with the enactment of several federal health insurance reforms since 1996, including the Mental Health Parity Act, DOL's enforcement role has significantly expanded. Accordingly, it has undertaken several initiatives to improve and expand its oversight, customer service function, and consumer and employer education efforts.[10] On April 6, 2000, DOL published its strategic enforcement plan to make public its goals and intended approach to ensuring that employee benefit plans comply with federal standards, including mental health parity.

In particular, DOL has begun to rely on investigations to more systematically determine health plan compliance. As of March 2000, DOL officials said that they had completed investigating approximately 200 employers that varied by size and geography. In addition to reviewing employers' compliance with other health and pension standards, DOL found that 12 percent of these employers' health plans that were subject to the Mental Health Parity Act were not in compliance. These plans typically retained annual or lifetime limits that were lower for mental health coverage than for medical and surgical coverage or contained other violations of the law. According to officials, DOL sends letters to noncomplying employers outlining the violations and in the vast majority of instances is able to work with the employers to correct them without resorting to litigation. DOL plans to regularly conduct more investigations, perhaps as many as 1,000 annually, to help evaluate compliance.

HCFA has a new regulatory role since the enactment of the Mental Health Parity Act and other recent federal insurance reforms. The agency must enforce federal requirements in states where it determines that legislation has not been enacted that meets or exceeds the federal standards or has otherwise failed to "substantially enforce" the federal standards. HCFA's activities in support of this role have been evolving since the Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996.[11] On August 20, 1999, HCFA issued enforcement regulations that prescribe how it assumes an enforcement role in a particular state and describe regulatory responsibilities it may perform.[12]

In mid-1999, HCFA undertook an initial state-by-state analysis of whether state laws conform to the federal standards-a precursor to its determining whether it is required to play an enforcement role in a particular state. HCFA officials said that this preliminary examination identified 7 states that appeared not to have laws addressing the federal parity standards, 24 states with laws about which the agency has questions concerning their conformance to the federal standards, and 20 states with laws that appeared to conform fully.

In December 1999, HCFA sent letters to the seven states that appeared not to have laws, indicating that it had a reason to question whether a state's standards

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[10] For additional information on DOL's initiatives, see Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards (GAO/HEHS-99-100, May 12, 1999) and Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998).

[11] For additional information on HCFA's activities, see Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States (GAO/BEHS-00-85, Mar. 31, 2000), (GAO/HEHS-99-100), (GAO/HEHS-98-67), and Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-217R, July 22, 1998).

[12] 64 Fed. Reg. 45,786 (45 C.F.R. Pt. 144,146,148, and 150).

substantially met the specified federal parity requirements. As of May 2000, HCFA officials said that four of these states have enacted conforming laws or other directives or have otherwise demonstrated that they enforce the federal parity requirements. In any of the remaining three states that do not meet standards through other regulatory means, HCFA will begin its formal determination process in which it could ultimately assume direct enforcement responsibilities. As of April 2000, HCFA was continuing to examine the 24 other states where it had questions concerning conformance, but it has not provided a specific time period for the completion of this review or the initiation of the formal determination process.

CONCLUDING OBSERVATIONS

The Mental Health Parity Act of 1996 sought to bring mental health benefits closer to parity with other health benefits. However, the scope of the law applies only to annual and lifetime dollar limits, allowing most employer-sponsored health plans to use other features, particularly hospital and office visit limits, to continue to provide less coverage for mental health than for other health services. The net effect is that consumers in states without more comprehensive laws have often seen only minor changes in their mental health benefits, resulting in little or no increase in their access to mental health services, and that the costs associated with the federal law have been negligible for most health plans. More than half of the states have enacted more comprehensive parity laws, requiring parity not only in dollar limits but also in service limits, cost-sharing requirements, or both, some of which have estimated cost increases of about 2 to 4 percent. Nonetheless, because the more comprehensive state laws apply only to a portion of the population and the federal law applies only to dollar limits and is disregarded by a significant minority of employers, many Americans are likely to remain in employer-sponsored health plans that continue to provide less coverage for mental illness than for other types of illnesses.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer questions from you and other members of the Committee.

GAO CONTACTS AND ACKNOWLEDGMENTS

For more information regarding this testimony, please contact Kathryn G. Allen at (202) 512-7114 or John Dicken at (202) 512-7043. JoAnne Bailey, Randy DiRosa, Mary Freeman, and Betty Kirksey also made key contributions to this statement.

STATE LAWS AFFECTING MENTAL HEALTH BENEFITS COMPARED WITH THE FEDERAL MENTAL HEALTH PARITY ACT

State	No law	More limited than federal law[a]	Meets federal law[b]	Exceeds federal law[c]	Full parity[d]
Alabama	X				
Alaska			X		
Arizona			X		
Arkansas				X	X
California[e]		X			
Colorado				X	X
Connecticut				X	X
Delaware				X	X
District of Columbia		X			
Florida			X		
Georgia				X	
Hawaii				X	X
Idaho	X				
Illinois		X			
Indiana				X	
Iowa	X				
Kansas				X	
Kentucky				X	
Louisiana				X	X
Maine				X	X
Maryland				X	X
Massachusetts		X			
Michigan	X				
Minnesota				X	
Mississippi		X			
Missouri				X	
Montana				X	X
Nebraska				X	
Nevada				X	
New Hampshire				X	X
New Jersey				X	X
New Mexico[f]			X		
New York				X	
North Carolina				X	
North Dakota		X			
Ohio		X			
Oklahoma				X	X
Oregon[g]	X				
Pennsylvania				X	
Rhode Island				X	X
South Carolina			X		
South Dakota				X	X

Tennessee				X	
Texas				X	
Utah	X				
Vermont				X	X
Virginia				X	X
Washington		X			
West Virginia			X		
Wisconsin		X			
Wyoming	X				
Total	**7**	**9**	**6**	**29**	**16**

Note: State laws in effect as of March 1, 2000.

[a]Law addresses mental health benefits but does not require parity in dollar limits. However, the law may require mandated mental health benefits, impose minimum service levels, or place limits on cost-sharing features for mental health benefits.

[b]Law requires parity in dollar limits but not in services or cost sharing.

[c]Law requires parity in dollar limits and requires parity in services or cost sharing or requires mandated mental health benefits.

[d]Law requires parity in all respects—dollar limits, services, and cost sharing—and also requires mandated mental health benefits.

[e]A law that exceeds the federal law becomes effective July 2000.

[f]A law that exceeds the federal law becomes effective October 2000.

[g]A law more limited than the federal law becomes effective July 2000.

Source: GAO review of data compiled by Tracy Delaney, the National Conference of State Legislatures' Health Policy Tracking Service.

RELATED GAO PRODUCTS

Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited (GAO/HEHS-00-95, May 10, 2000).

Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States (GAO/HEHS-00-85, Mar. 31, 2000).

Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards (GAO/HEHS-99-100, May 12, 1999).

Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-217R, July 22, 1998).

Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998).

(201061)

[1]Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited (GAO/HEHS-00-95, May 10, 2000).

[Editor's Note: Due to the high cost of printing, the materials supplied by Ms. Allen entitled: "Employers' Mental Health Benefits Remain Limited Despite New Federal Standards and Despite New Federal Standards, Mental Health Benefits Remain Limited" may be obtained from the U.S. General Accounting Office]

The CHAIRMAN. Next, I am happy to introduce Dr. Steven E. Hyman, director of the National Institute of Mental Health at the National Institutes of Health in Rockville, MD.

During Dr. Hyman's tenure at NIMH, the Institute has emphasized research on brain behavior and genetics; has placed priority on converting discoveries into research on mental disorders and forms of treatment, including clinical trials; and has focused on child development and childhood mental disorders.

Previous to his service at NIMH, Dr. Hyman was a professor of psychiatry at Harvard Medical School and director of psychiatric research at Massachusetts General Hospital in Boston. He is a graduate of Yale and of Harvard Medical School and earned his M.A. from the University of Cambridge.

Dr. Hyman, we appreciate your testimony before us today and look forward to your remarks.

Dr. HYMAN. Thank you very much for that kind introduction.

We are here today because of your interest, Mr. Chairman and Senator Kennedy, in this issue but also because of the sustained attention of Senators Wellstone and Domenici. But we are also here, if you reflect on it in the year 2000 to think about equality of treatment of mental and physical disorders because of a history of bad science and bad ideas which have artificially separated mental disorders from other disorders that affect human beings.

Although I will address briefly in my 5 minutes the economics research relevant to the consideration of parity, I would like to begin by putting the matter in the context of biomedical research. Specifically, I will briefly present research findings that indicate that mental disorders are real, tragically disabling, readily diagnosable, and treatable. Mental disorders are disorders of an organ in the brain, just as coronary artery disease is an illness of another organ—the heart—and these disorders can be diagnosed with a high degree of reliability.

We have just heard some counter-examples which I think we should address, which are the differences in rates of diagnosis of attention deficit disorder in children, from almost no children in some inner cities to as many as 20 percent of boys in some middle-class suburban counties.

But I think it is important to State that it is not that we cannot make diagnoses. We can make diagnoses with certainty. The problem when we see these variabilities in mental illness really has to do with the ability of practitioners to follow appropriate guidelines. And I think a lot of these disparities reflect issues of training and following guidelines. I would also point out that this is by no means unique to mental health. It took more than a decade to alter practitioner behavior to get them to treat peptic ulcer disease with a course of antibiotics that would block recurrences instead of with treatments that would, say, just stop acid secretion. So the issue of following guidelines is not unique and is not a reason to consider mental health to be other.

Now, what is the impact of mental disorders on our society? Here, Senator Kennedy has already preempted one of my reports, but I think it is very important to discuss briefly "The Global Burden of Disease" study which was put together by the World Bank

and the World Health Organization with the help of the Harvard School of Public Health. The study examined the consequences of 107 types of diseases and injury, recognizing that traditional measures of disease burden such as prevalence alone—the common cold is prevalent but does not have much of an impact—or mortality—sudden death in old age does not have much economic impact—has really little grasp on us.

What really matters is to understand how disease contributes to healthy years of life lost to illness, whether due to disability or to premature mortality. And when they did that, they found that mental illnesses, as Senator Kennedy has already presented, contributes an enormous degree of disease burden. If we just look at rank causes of disability in the United States, major depression is the leading cause of disability, alcohol use second, schizophrenia fifth, bipolar disorder sixth, and obsessive-compulsive disorder ninth.

Clearly, we cannot have a healthy and productive work force unless we address these causes of disability.

It is also very important, as some of you have already addressed, to think about children. In the Surgeon General's report, it was noted that 5 to 9 percent of our children have a level of disability due to mental illness such that they cannot interact normally with family, form normal and healthy peer relationships, or make use of their education in an appropriate way.

In addition, if I could have the next chart, we have already heard about youth suicide. You can see the upward trend, although now stable, to a truly unacceptable youth suicide rate of 10 per 100,000. And as has been mentioned, in different age subgroups, suicide is the second or third leading cause of death among youngsters. Suicide accounts for more deaths than cancer, AIDS, and all infectious diseases combined for children. This is a very important issue to bear in mind.

We have heard about the issues of disability with respect to adults. We now recognize that individuals with depression have between one and a half and three times more days of work missed due to disability than people who are not depressed, and that treatment can entirely reverse this level of disability.

I am not going to deliver a mind-numbing lecture on brain research, but I just want to take one example to show you the equivalence of mental disorders with other disorders of the body, and it comes from genetics—and again, I will not discuss all the numbers on this chart. I just want to point out that when geneticists look at mental and physical disorders, autism, manic-depressive illness and schizophrenia turn out to be more genetic than adult-onset diabetes melitis. So again, the idea that there is something special or different about mental disorders is not at all borne out by the biomedical research.

Senator KENNEDY. Could you just repeat that? I got the concept, but I just want to know the extent—excuse me, Mr. Chairman.

Dr. HYMAN. Based on studies of families, identical twins, people with 100 percent of their DNA in common, and similarities between parents and normal siblings, we can look at the contribution of genes to risk of illness. Now, the genetics is complex in the sense that you know, for example, that for diabetes or schizophrenia,

often, you skip generations, and that is because more than one gene is required for the risk, so you need an unlucky combination. But when you look at the total contributions of genes to risk—and I have just rank-ordered the disorders on this chart—if you have an identical twin with autism, you have a 2,000-fold increased risk of having autism. If you have a sibling with autism, you have a 100-fold increased risk of autism. If you have Type 2 diabetes, adult-onset diabetes, in an identical twin, you only have—it is significant—but a 16-fold increase in risk. And if you have a brother or sister with adult-onset diabetes, you have a two- to three-fold increase in risk.

So you can see going down those numbers that genes contribute to autism, manic-depressive illness and schizophrenia enormously; they also contribute to risk of depression and attention deficit disorder. So again, this is to undo this unwarranted separation of the mental and the physical.

Over the next decade, we will almost certainly discover the genes that create vulnerability to the miswiring of the brain that occurs in schizophrenia and to the mood swings that we see, for example, in manic-depressive illness.

I will just briefly turn to the economics, because I think my colleague from the GAO has really answered many of the concerns that you have, but I think it is important to note that we recognize the need to keep overall health care costs within bounds and at the same time to ensure that we have a healthy and productive population and healthy children.

According to our most recent analysis, which was requested by the Senate Appropriations Committee, implementing parity benefits does not cause any substantial increase in health care treatment costs, and we have just heard that from GAO as well. Moreover, in the case of depression, where we have the data, there is an increasing body of evidence showing cost offsets. Now, I mentioned indirect cost offsets in terms of disability, but there are also direct medical cost offsets—that is, people with depression tend to have about a 50 percent greater utilization of general medical health care which is reversed with appropriate treatment of depression—and again, we could talk about more examples.

The general experience with parity, despite marked differences from State to State, is that parity creates enormous incentives for managed care. In fact, there are no really large examples of parity being instituted without increased used of management tools. These have achieved savings but at a cost of treatment intensity, and we do not yet know what this cost in terms of treatment intensity is.

We recognize that the largest decreases in general, based on a detailed analysis of experience of a large State and also looking at many of the other States that have parity, is a decrease in the use of inpatient treatment for youth. In some States, there has been a decrease in days spent in the hospital of as much as 75 percent in youth. Whether this has an impact on quality and outcomes is something that we at NIMH really do need to understand.

In general, however, with all of those caveats, our current best model is that parity leads to a health benefit cost increase of about

1.4 percent and, depending on the strength of the management tools used, perhaps less.

I would be pleased to answer any questions.

[The prepared statement of Dr. Hyman follows:]

PREPARED STATEMENT OF STEVEN HYMAN, M.D.

Mr. Chairman and Members of the Committee: I am Dr. Steven Hyman, director of the National Institute of Mental Health (NIMH). I am delighted to participate in this important and timely hearing on mental health insurance parity, sharing this panel with my colleagues from the General Accounting Office. I am deeply appreciative of the sustained attention that Senator Domenici and Senator Wellstone have directed to the issue of mental disorders and I thank the Committee for its interest in the topic.

Over the past two decades, NIMH has assigned priority to research on the organization and financing of mental health services. Within the past 8 to 10 years, at the request of the Senate Appropriations Committee, the Institute and its National Advisory Council have developed a series of reports on parity of insurance coverage between mental disorders and general medical disorders. Three of the Reports, developed in 1992, 1997, and 1998, are compiled in a document that is currently available from NIMH, electronically on our home page (www.nimh.nih.gov) and as a monograph. A fourth report is undergoing final review as we speak.

I will not address technicalities of the economics research relevant to consideration of parity. Rather, I would like to broaden the context of the Committee's consideration of parity by discussing some of the mental illness research findings that have brought us to a point where this hearing is a next needed step in consideration of our Nation's mental health policies. Specifically, I will present research findings indicating that mental disorders are "real" and often tragically disabling illnesses that affect millions of Americans; that these are disorders of an organ, the brain, just as coronary artery disease is a disorder of another organ, the heart; that these disorders can be diagnosed with a high degree of reliability; and that treatments of well-documented efficacy exist. Growing appreciation of these points accounts for and is reflected in significant changes in public attitudes about mental illness.

The release last December of the first-ever Surgeon General's Report on Mental Health was a landmark event in this ongoing sea change in public understanding and attitudes. Dr. Satcher brought front and center to the American public a scientific discussion of topics that desperately need open and continuing discussion. I might note that the NIMH web site that I mentioned earlier, that links to the Surgeon General's Report and also provides abundant information on specific mental disorders and on NIMH-funded research, has been visited by more than 6-and-a-half million people just within the past month. After a dismally long period marked by stigma and misunderstanding, Americans are hungry for information about mental disorders and mental health.

THE BURDEN OF ILLNESS

What impact do mental disorders have on our society? A watershed in our understanding of the impact of mental disorders is the 1996 Global Burden of Disease (GBD) study, conducted for the World Bank and World Health Organization by Drs. Christopher Murray and Allen Lopez of Harvard University. This study examined 483 separate consequences of 107 diseases and injuries with the recognition that traditional measures of disease burden, such as prevalence or mortality, do not really lay bare the impact of disease on economies or on societies at large. For example, colds are highly prevalent but cause no serious impairments and sudden death in old age has little economic impact. The GBD defined a concept called the Disability Adjusted Life Year (DALY), which refers to healthy years of life lost to either disability or premature mortality. Based on this measure of disease burden, mental disorders-which are prevalent, often begin early in life, and frequently are characterized by recurrent episodes (as in depression) or chronicity (as in schizophrenia)-produce a disproportionate share of DALYs, much of which is due to disability. Indeed, according to the GBD, in the U.S.-and throughout the developed world-depression is the leading cause of disability, and bipolar disorder, schizophrenia, and obsessive-compulsive disorder are found among the top ten causes (see Table 1).

The study's authors note: " . . . The burdens of mental illnesses, such as depression, alcohol dependence, and schizophrenia, have been seriously underestimated by traditional approaches that take account only of deaths and not disability. While psychiatric conditions are responsible for little more than one percent of deaths, they account for almost 11 percent of disease burden worldwide."

There remain, of course, methodologic problems in quantifying disability, and these problems are even more pronounced in quantifying disability in children. Nonetheless, the Surgeon General's report estimates that approximately 20 percent of those under age 18 have mental disorders that result in mild functional impairment; a smaller subset of children-between 5 and 9 percent-experience severe functional impairments; by that, I mean they are severely limited, or handicapped, in their ability to interact happily and healthily with their families and friends, to engage fully in school activities and to acquire the skills and knowledge that set the developmental path for a productive, satisfying adult life. For children, an untreated mental illness is doubly tragic because it may not be possible to recover the lost period of learning and social development needed to produce healthy, skilled, and productive individuals who can live up to their innate potential. Moreover, there is increasing evidence that, as in all chronic diseases, the earliest possible diagnosis and intervention may minimize severity and ultimate functional impairment. Recent tragic episodes of violence in our schools remind us that inadequately treated emotional and behavioral disorders among our children can literally have lethal consequences in terms of suicide and murder. Of course, untreated mental disorders in children also markedly impair the ability of parents to work productively. The need for appropriate treatment of childhood mental illness is vital, and the payoff is immense.

A steadily improving, research-based understanding of disability, or the functional impairments associated with illness, is critically important, for policy deliberations often come down to tough decisions about how best to use limited resources-public and private-to provide effective care for those problems that cause the greatest disability. This point is particularly germane to consideration of insurance parity. The Global Burden of Disease data make it strikingly clear that we cannot have a healthy work force in the United States, or for that matter a nation of children behaviorally and emotionally ready to learn in school, without broad access to high-quality treatment for mental illnesses. It is fortunate that at the same time research is documenting the perils of failing to treat mental and behavioral disorders, it also has shown that mental disorders can be diagnosed with an adequate degree of certainty.

For the most common mental disorders, efficacious treatments exist that, for the most part, are as good or better than treatment for most of the chronic somatic illnesses of greatest concern in the United States. Dr. Ronald Kessler and colleagues recently analyzed data from two national surveys and found that the odds of having any short-time work disability are 37- to 48% higher among employees with major depression than among all other workers (17- to 21%). Untreated depression leads workers to miss between 1.5 and 3.2 more workdays in a month than all other employees, resulting in salary-equivalent disability costs averaging between $182 and $395 per depressed employee. Data from a recent primary care depression treatment trial found the cost of effective pharmacotherapy for depression to be $402 per 30 depression-free days; thus, the investigators estimate that between 45% ($182/402) and 98% ($395/402) of the costs of treating the employees' depression would be offset by increased work productivity associated with symptom remission. The researchers noted, moreover, that the cost-effectiveness margin for employers may be even greater, since untreated depression entails additional hidden costs and because employees, rather than employers, pay insurance costs over the long term in the form of wage adjustments (Kessler et al, Health Affairs, 18. (5):163-171, 1999)

RESEARCH ON THE BRAIN AND BEHAVIOR IN MENTAL ILLNESS

A broad scope of research, including neuroscience, genetics, brain imaging, behavioral science, and clinical investigation has taken us far beyond the impoverished and stigmatizing conceptions of diseases such as schizophrenia, autism, or manic-depressive illness left us by history.

Perhaps the most important message I can leave with the Members of the Committee today as you deliberate how we treat mental disorders is that we have found no reason based on biomedical or behavioral science why mental disorders should be treated differently from any other medical disorder. Try to explain to the family member of a person with schizophrenia why Parkinson's disease-a chronic and not yet curable disease that affects dopamine systems in the brain-might be fully covered by insurance while schizophrenia-another chronic and not yet curable disease that affects dopamine systems in the brain-is not. Think of how you might explain to the parent of an autistic child why chronic genetic diseases that cause childhood seizures might be fully covered but why a highly genetic brain disease such as autism is not.

STUDIES OF GENES AND MENTAL DISORDERS

Based on family and twin studies, there is no doubt that the major mental disorders are genetic disorders. Indeed, the genetic risk associated with autism is greater than that observed for such general medical disorders at type II diabetes mellitus (See Table 2). While diseases like schizophrenia, autism, manic-depressive illness, major depression, attention-deficit/hyperactivity disorder, anorexia nervosa, and many others are genetically complex, meaning that risk is due to a combination of multiple genes and nongenetic, or environmental, factors, we are well on the way to discovering the relevant genes. This is the same state of genetics research in many other common illnesses with genetic components of risk such as the common forms of type II diabetes or coronary artery disease.

STUDIES OF THE BRAIN IN MENTAL DISORDERS

The control of thinking, emotion, movement-indeed, all behaviors-depends on the function of many specific "circuits" in the brain. These circuits are composed of nerve cells that communicate with each other by means of chemicals called neurotransmitters. Disease can attack the brain in several ways that alter its function and, in turn, mental life and behavior. The simplest case is when brain cells die. This happens, for example, in a stroke, when a blood clot deprives cells of oxygen. The precise behavioral deficit created by a stroke depends on which cells die and, therefore, which circuits are disrupted. Alzheimer's disease, considered a mental illness until recently (indeed the distinction between mental disorders and many other brain diseases is quite arbitrary), is a disease in which abnormal substances, called plaques and tangles, accumulate in nerve cells, eventually resulting in their death.

In strokes and Alzheimer's disease, we can look in a microscope and see dead or dying cells and other brain pathology. But the brain can malfunction substantially even without cells dying or displaying pathologic structures: If the brain is "wired up" incorrectly during brain development, as we believe to be the case in autism and schizophrenia, there are terrible behavioral consequences without dramatic gross or microscopic pathology. Specific neuropathology has been identified, however, in schizophrenia, in the form of changes in the ventricular system in the forebrain, and various other morphological changes have been reported as well. At the same time, it is important to separate research findings from clinically useful tests: Although today there is no single abnormality on a brain scan that would allow us to make a diagnosis of schizophrenia in an individual, from the point of view of research, brain abnormalities that are characteristic of schizophrenia have been solidly established. Fortunately, for clinical purposes, the symptoms and behavior generally make the diagnosis clear.

One step farther from the example of a stroke is a severe mood disorder, such as major depression or manic-depressive illness. A person suffering one of these recurrent, episodic disorders may function entirely normally prior to the onset of illness, and may have periods of remission in which they function normally again. We do not believe that these individuals suffer gross nerve cell death or fundamental miswiring or else they could not improve with treatment to the point of normalcy. Diseases like manic-depressive illness represent serious, but reversible abnormalities in the function of specific brain circuits. This is not hocus-pocus; we are quite familiar with this kind of disease in medicine. Each year several thousand Americans die of an abnormal heart rhythm called ventricular fibrillation. Many of these people have never had a heart attack. On a postmortem examination, the pathologist does not see a malformed heart or even an abnormal pattern of wiring in the heart. What has killed these people is potentially reversible, but often lethally abnormal electrical activity in the anatomically normal circuits that control their heart rhythms. In the case of mania or depression, what disables-and all too often kills-is abnormal functioning of specific neural circuits as a result of genetic vulnerability acting together with triggers from a person's environment or experience.

Over the next decade, we almost certainly will discover the genes that create vulnerability to the miswiring of schizophrenia and of autism and to the abnormal circuit function of mood disorders.

COVERAGE OF MENTAL HEALTH CARE

At the beginning of my statement, I noted that that NIMH, through its National Advisory Mental Health Council, has been directed to undertake several studies examining the question of parity in financing mental health services. In 1992, the Senate Appropriations Committee asked the Council to prepare a report "on the cost of covering medical treatment for severe mental illnesses commensurate with other

illness and an assessment of the efficacy of treatment" for designated disorders. In its report accompanying the 1997 appropriations bill, the Committee requested that the Council report on then-available data about the costs of providing equitable coverage for people with "severe and clearly identifiable, diagnosable, and treatable" mental disorders. In the following year's report, the Committee requested additional reports as data became available, and inquired explicitly about the impact of managed care on access to mental health services, and on the quality of the care that is made available.

Most recently, the Committee requested health services research data that would, where possible "...address both employer direct costs, and the impact of indirect cost savings from successful treatment of employees." The Advisory Council was asked also to "consider the costs and quality of coverage for children, and the development of outcome measures of quality for all mental health coverage."

That inequities related to the status of mental disorders in health insurance exist is indisputable. While keeping overall health care costs within bounds is a matter of importance to all Americans, the research that I have described today shows no biomedical justification for differentiating serious mental illness from other serious and potentially chronic disorders of the nervous system such as stroke, brain tumor, or paralysis. That is, there is absolutely no biomedical justification for policies that judge mental disorders as being in any way less real or less deserving of treatment, and an extensive body of rigorous research has demonstrated that treatment for mental disorders is both precise and cost-effective.

Given the onset of many mental disorders in childhood, adolescence, and early adulthood, and the serious repercussions for the long-term productivity of members of our society of leaving these disorders untreated, the need for access to treatment seems particularly acute.

NIMH takes seriously its responsibility for supporting the wide array of research needed to demonstrate that mental disorders are real, diagnosable, and treatable. It is on the foundation of this research that NIMH responds to requests, such as those from the Senate Appropriations Committee, to examine various issues related to insurance benefits for mental health treatment.

According to our most recent analysis, both new research and re-estimates of previous efforts to model the impact of parity initiatives, indicate that implementing parity benefits does not cause any substantial increases in health treatment costs.

NIMH will continue to study and monitor the impact of parity in the years ahead. At present, 30 States have passed some form of parity legislation. The models adopted by different States vary widely, with benefits that range from limited to comprehensive. These programs afford the Nation a wealth of opportunities to assess the impact of parity initiatives. A critical question that remains to be answered is what impact mental health insurance parity has on the quality of care and its implications for public health.

Thank you, Mr. Chairman. I will be pleased to answer questions.

The CHAIRMAN. Thank you very much. That was certainly wonderfully enlightening testimony.

I would ask both of you to please discuss how you view the role of managed care in controlling costs under parity laws, such as reducing the use of inpatient care by increasing access to outpatient care. What happens to cost when managed care is not available?

Dr. HYMAN. I would be delighted to answer that. In our models, in a fee-for-service model, there are clearly more substantial cost increases than there are with managed care. In the real world, as I mentioned, there are no examples of creating substantial parity without increasing the incentives for managed care. Our real world examples actually come from the combination of parity with managed care.

In one large State where parity was instituted, we actually saw an enormous decrement by year three in overall cost as a result of decreasing inpatient hospital days. Now, again, we do not yet know what this means for the health of individuals with mental illness. Insofar as there truly is greater access to outpatient treatment which, combined hopefully with a decrease in stigma, would lead to earlier diagnosis and treatment, it may well be that managed

care will improve the health of individuals by getting them into treatment earlier and not requiring that they be hospitalized.

However, insofar as the overall intensity of treatment including outpatient treatment decreases, I think that you then have a situation in which the health of people with mental illness would be adversely affected. And it really remains to be seen what the impact of management on quality is.

The CHAIRMAN. Ms. Allen.

Ms. ALLEN. I would add to that that our findings in surveying employers would support that. Eighty-nine percent of the employers who responded to our survey indicated that they do have managed care as part of their health plans, most commonly using the preferred provider organizations, PPOs, and HMOs. That has not increased substantially since 1996. In other words, they had not made extraordinary increases because managed care was already a very important part of their plans.

That probably explains very largely why they did not report significant cost increases to us, because many of them already had those techniques in place.

The CHAIRMAN. Thank you.

Ms. Allen, the Mental Health Parity Act prevents employers from imposing certain kinds of limitations on access to mental health services. Please discuss how employers have responded by imposing other limitations in order to control costs.

Ms. ALLEN. The majority of the employers did institute at least one other restriction beyond the annual lifetime limits once those went into place. Most commonly, these would be limits, such as 30 days on inpatient hospital days, or 20 outpatient visits per year.

Another significant cost-sharing device that was more prevalent that has been instituted recently has to do with sharing of cost for outpatient visits—for example, a 50 percent requirement for cost-sharing for outpatient visits as opposed to 20 percent for others.

So those are the most prevalent reactions that they have made.

The CHAIRMAN. Dr. Hyman, do you have a comment?

Dr. HYMAN. No. I think that that is in absolute agreement with the data from our parity work group.

The CHAIRMAN. Ms. Allen, what reasons has HCFA given for taking this amount of time to evaluate State laws and enter as an enforcement authority where necessary? Can we attribute HCFA's slow rate of progress to a lack of experience in dealing with private health insurance?

Ms. ALLEN. Mr. Chairman, as you well know, this Act as well as HIPAA, the Health Insurance Portability and Accountability Act, gave HCFA a new role in the area of insurance regulation, and it has been working for 2, 3, or 4 years now to try to put this mechanism in place.

Early on, it felt a need to add additional expertise for it to carry out its responsibility, and they feel like they have been successful in doing that in terms of drawing in some additional expertise both in the central office and some of the regions where they have enforcement responsibilities.

But at the same time, HCFA will admittedly say that it has intentionally pursued a more deliberate approach to afford States every opportunity to come into conformance on their own—in other

words, not designed to step into the arena which has normally been one of State regulation.

Having said that, though, they have identified a number of States now, and that number is decreasing in terms of States that tend not to be conforming to the Federal law, and they are continuing to work with those States to bring them into compliance.

At the same time, HCFA has identified about 24 States where they have some reasonable question as to whether or not they are complying. So HCFA recognizes the need to make more contact with those States. In a recent report to you, we recommended that HCFA pay a little bit more attention and provide us and yourselves with some idea of the schedule that they are working on to assess those other States, and they indicate that they will do that shortly.

The CHAIRMAN. A comment, Dr. Hyman?

Dr. HYMAN. No. This is something that the GAO has looked into that we have not been involved in.

The CHAIRMAN. All right.

Senator Reed.

Senator REED. Thank you, Mr. Chairman.

Thank you both for your testimony.

Ms. Allen, when you were conducting your review, did you also look at reimbursement rates for mental health professionals, and did you draw any conclusions or correlations between access to service and reimbursement rates?

Ms. ALLEN. No, Senator. I am afraid we did not include that as part of our review.

Senator REED. Is that something that, based upon your review, you think would be useful to pursue further?

Ms. ALLEN. I think it would be very interesting to look into.

Senator REED. Dr. Hyman?

Dr. HYMAN. I do. The major data we have on the techniques for decreasing cost is this decrease in inpatient stays, which was especially marked for dependents, especially adolescents and children. In one case study, inpatient hospital days for adolescents decreased by 75 percent, and as I already mentioned to the chairman, we have no idea what the impact of that is at this time. We also did not analyze separately reimbursement to practitioners.

Senator REED. Are there any other motivations, aside from cost, to avoid full compliance with the parity law, based upon your experience?

Dr. HYMAN. That is a very important question, Senator. As a physician and a scientist, when I look at the data about these illnesses, I can find absolutely no reason to separate medical and physical illness. Indeed, it seems entirely arbitrary.

One of the things that is in my written testimony but bears repetition is just think about explaining to one of your constituents why Parkinson's disease, a chronic illness affecting dopamine systems in the brain, has one kind of coverage, and schizophrenia, a chronic illness affecting dopamine systems in the brain, has a different kind of coverage; or to a parent why autism, a highly genetic disease affecting child development, has lesser coverage than other genetic diseases like some childhood epilepsies.

In biomedical research, there is absolutely no justification for treating this as a separate class of illnesses.

Senator REED. So, it is just cost avoidance, trying to avoid the cost as best you can.

Dr. HYMAN. It appears that way, and it appears that again, history has brought us to this pass, and it is entirely arbitrary.

Senator REED. Let me follow up again with your study, Ms. Allen. In terms of your analysis and review, did you look at the issue of comorbidities, like drug dependency and substance abuse and mental health, and whether problems with co-occurring disorders are more acute than having one diagnosis?

Ms. ALLEN. We did not report exactly on those dimensions, but at the same time that we were analyzing the increased cost that employers might incur, we looked at the studies that pertain to States that have adopted full parity, and the indication there was that often there is co-morbidity, and a person may be treated for more than one condition. And in those States that have full parity, for substance abuse as well as some other conditions, the costs, quite frankly, are not that excessive and are in fact rather modest for full parity.

Senator REED. However, in your review—and Dr. Hyman, your comments would be appreciated as well—you don't perceive a systematic bias against those people with comorbidities, i.e., you might have a mental disorder, but if you have a substance abuse problem, and they put you in the substance abuse treatment system, where there is a long waiting list for treatment——

Dr. HYMAN. Senator, it is a very important question. Indeed, in many States, the substance abuse problem may go untreated. It is very common for people with manic depressive illness, for example, to abuse alcohol or to become dependent; and if you do not treat both, we know, and there is a lot of data to suggest, that outcomes are very, very poor. The interaction between mental illness and substance abuse is intimate. We know, for example, just looking at the preventive angle, that if we do not treat attention deficit—something I mentioned earlier—appropriately in children, they have a very high likelihood of going on to substance abuse, and indeed, tragically, they have a high likelihood of going on to being in the criminal justice system.

Senator REED. Is it possible that there are people who are not reported with what you would list as mental conditions like bipolar disorders, etc, because they have a substance abuse problem and they are lumped into the substance abuse category, and as a result, we are not even beginning to realize the untreated mental health problems in America?

Dr. HYMAN. I think that what you say is true and even more true especially among incarcerated youth, that there is an enormous amount of undiagnosed and untreated mental health problems. And again, of course, these children will 1 day be returned to society, and without recognition and treatment, they will not do any better or become productive citizens.

Senator REED. Let me ask another question following on your comment, Dr. Hyman. You seem to be saying that everyone is being disadvantaged equally; children are being shuffled out of the system because they have mental health problems——

Dr. HYMAN. Correct.

Senator REED [continuing]. And in fact, one does not want to make these distinctions, I think, but early intervention in someone's life with mental health care and/or biological health care seems more decisive. It would seem to suggest that we should do even more for children. Is that a credible proposition?

Dr. HYMAN. Senator, if a child cannot use school—if they have an untreated depression, they are just going to miss these critical developmental opportunities, and it is not at all clear that they could go back later and somehow make that up.

Although fortunately rare, the very tragic school shootings that this Nation has been reeling in response to reflect part of the risk of not recognizing and intervening in mental disorders. Many of these young perpetrators actually had unrecognized and untreated mood disorders, and because they were not the kids who were out of their seats and making trouble, but were often withdrawn and sullen and angry, but contained for a long time, they were missed and not treated, and the consequences, of course, are tragic.

Senator REED. Thank you, Doctor.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

I would like to thank both Ms. Allen and Dr. Hyman for their fine testimony, and I would like to thank Senator Reed for some really penetrating questions.

I want to say to my colleague from Rhode Island that I could go on for hours about this issue that Dr. Hyman mentioned of this increasing trend, which is hard to believe in the year 2000, toward warehousing a lot of people with mental illness in our prisons and our jails. I have seen some of these facilities with the National Mental Health Association people and others in this country, and it is really quite brutal. There are a lot of kids who do not get any treatment and probably should not even be there, and when they are there, their problems get even worse.

The other point is that I am appreciative—and I thought I was reading your face, Dr. Hyman—of Senator Reed's question about substance abuse. All too often, these are co-occurring problems, and I just want to say that I have a bill with Senator Specter, the Fairness in Treatment Act, that tries to deal with this. If we think there is stigma, and all of this is viewed as moral failing in the mental health area, when it comes to substance abuse, it is much worse. So I am hoping and praying for a time when people in the recovery community will speak out about what treatment has meant to them and how they have been able to lead productive lives.

Mr. Chairman, let me first of all ask that our record be kept open for the final NIMH Advisory Council report.

Dr. HYMAN. It is in clearance now.

Senator WELLSTONE. Yes. When it is cleared, I would like to have that be made a part of our record.

The CHAIRMAN. That will be done, and we certainly welcome the report.

Senator WELLSTONE. That is where that 1.4 percent figure that Dr. Hyman pointed out on cost comes from.

[The document referred to follows:]

INSURANCE PARITY FOR MENTAL HEALTH:

COST, ACCESS, AND QUALITY

Final Report to Congress by the

National Advisory Mental Health Council

EXECUTIVE SUMMARY[1]

Building upon a body of knowledge developed in the course of three prior NAMHC reports on parity to the Senate Appropriations Committee, an analysis of recent studies reveals the following major findings:

What is the current status of parity legislation in the US? Thirty-one of the 50 States have now passed some form of parity legislation, with benefits that range from limited to comprehensive. The 1996 Mental Health Parity Act (which is now being considered for reauthorization) appears to have accelerated the passage of State-level parity legislation. And in mid-1999, President Clinton announced that a parity-level benefit would be implemented for 8.7 million beneficiaries of the Federal Employees Health Benefit Program (FEHB) beginning in calendar year 2001.

Does implementing parity increase the total cost of health benefits? Recent research supports and expands earlier findings that implementing parity benefits results in minimal if any increase in total health care costs. A recently updated simulation model estimates an approximately 1.4 percent increase in total health insurance premium costs when parity is implemented. In addition, data from a large State show that total health care costs decreased after the implementation of parity.

Does implementing parity cause cost shifting between different health system sectors? The issue is complex. Data are not available under parity, but recent research indicates that high-cost consumers may not shift completely to coverage under the public system; rather, some may be covered by both the private and public systems. The implications of this finding remain unclear.

How does parity affect access and quality? A recent study with a large State database shows that when parity mental health benefits are introduced with managed care, an increased proportion of adults and children used some outpatient mental health services. However, the intensity of services (number of visits) did not increase and inpatient use declined. Although the reduction in inpatient use was most pronounced for children, there was evidence that their access to specialty mental health services increased. What is unknown is the quality of care and impact of these changes.

How can the quality of mental health services be measured and improved? Although research in this area offers the promise of new and feasible measures, no currently available quality measures provide all the answers that consumers, providers, employers and policy makers want. Even with appropriate measures of quality and the ability to put them into place, interventions need to be developed that actually improve the quality of mental health care. Some recent evidence suggests that even small-scale interventions can ensure the delivery of appropriate services.

How does parity or managed care affect disability and productivity in the workforce? Data are not yet available to assess the impact of parity in these areas. However, studies under non-parity conditions suggest that mental health services can decrease the amount of lost wages and reduce lost days from work and the number of disability claims.

In summary, mental health parity is now the law in the majority of States. The cost of parity in combination with managed care is less than initially anticipated, and it has some beneficial effects on access. Yet, it is still unclear what impact parity has on the quality of mental health services and the well-being of people with mental illnesses. As Mechanic and McAlpine note in a recent issue of Health Affairs:

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[1] NOTE: This report does not necessarily reflect the views of the Department of Health and Human Services.In Senate Report No. 105–300, the Senate Appropriations Committee observed,"The Committee has recently received from the National Advisory Mental Health Council [NAMHC] the report requested in its fiscal year 1998 appropriations report and notes the impact of managed care on keeping costs of parity at a low level." The Committee requested from the NAMHC an additional report on its findings from emerging health services research data that would, where possible ". . . address both employer direct costs, and the impact of indirect cost savings from successful treatment of employees." The NAMHC was also asked to "consider the costs and quality of coverage for children, and the development of outcome measures of quality for all mental health coverage." This report was developed in response to the Committee's request.

"The challenge for the coming decade is to develop clear standards based on the best evidence and clinical judgment so that parity has substance in implementation as well as in concept. Parity is not simply some match in service limits to what a medical or surgical patient experiences. It should be a configuration of management strategies fitted to careful assessment of patients' needs and a response that is consistent with our best scientific knowledge." (Mechanic and McAlpinel 999)

It remains to be seen how the balance will be struck over the next few years between State legislation, large employer initiatives (public and private), and federal legislative expansions of the 1996 Mental Health Parity Act.

I. INTRODUCTION

A. Charge

This report is one of a series developed by the NAMHC in response to requests by the Senate Appropriations Committee.[2] In Senate Report No. 105–300, the Senate Appropriations Committee observed:

"The Committee has recently received from the National Advisory Mental Health Council the report requested in its fiscal year 1998 appropriations report and notes the impact of managed care on keeping costs of parity at a low level." The Committee requested from the NAMHC an additional report on its findings from emerging health services research data that would, where possible ". . . address both employer direct costs, and the impact of indirect cost savings from successful treatment of employees. The NAMHC was also asked to "consider the costs and quality of coverage for children, and the development of outcome measures of quality for all mental health coverage." (For the full Senate language, see Appendix A.)

The prior NAMHC report (1998) presented the results of research studies that focused on the indirect effects of managed mental health care on general medical care and disability as well as the quality of mental health services in the primary care setting. That report also summarized the efforts at that time to develop clinically based quality information systems in managed care. In addition, the report reviewed the existing research findings that evaluated the quality of managed mental health services both on the basis of administrative claims data and clinical outcome data. This report updates, refines, and expands those earlier findings, often with much larger databases.

B. Background: The Changing Policy Context

Since 1993 when the first NAMHC report was published, the U.S. health care system has undergone many changes that profoundly affect both mental health and general health care. Of particular importance is the ongoing search for ways to control the costs of health care while maintaining quality and accessibility. One major structural change intended to contain costs has been the shift to managed care after decades of predominance by fee-for-service insurance. Intertwined with this change have been increasing efforts at the State and federal levels to mandate health insurance coverage for treatment of mental illness that is comparable to that for other illnesses also known as "parity."[3]

In the 1990s, a growing number of States enacted their own parity legislation. in addition, the Mental Health Parity Act (MHPA) of 1996 (P.L. No. 104–204), implemented on January 1, 1998, provided an important step toward parity for all States. The MHPA amended the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act of 1974 (ERISA) to provide for parity in applying dollar limits on certain mental health benefits when limits are placed on medical and surgical benefits. The MHPA stipulates that when a group health plan-or health insurance coverage offered in connection with a group health plan—provides both medical and surgical benefits as well as mental health benefits, it may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits if it does not also impose such a limit on substantially all of the medical and sur-

[2] The prior reports are contained within one document: National Advisory Mental Health Council (1998): Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality. An Interim Report to Congress by the National Advisory Mental Health Council, Bethesda, NIH Publication No. 98–4322.

[3] The term "parity" or "mental health parity" refers generally to insurance coverage for mental health services that is subject to the same benefits and restrictions as coverage for other health services. "Comprehensive" parity legislation eliminates the use of different annual and lifetime dollar limits, inpatient day and outpatient visit limits, deductibles, and out-of-pocket maximums in mental health compared to general health benefits. The Mental Health Parity Act of 1996 affects annual and lifetime dollar limits, so that day and visit limits and higher co-payments and deductibles may still be applied to those with mental illnesses. In some State legislation, although not in the Mental Health Parity Act, mental health parity may only apply to a subgroup of the population (e.g., those with specific mental illnesses).

gical benefits. The MHPA also provides two exemptions from these requirements: the first is for small employers (defined as an employer with at least two but not more than 50 employees); the second is for group health plans if the application of these provisions results in an increase in the cost under the plan or coverage of at least 1 percent. In theory, the new national parity legislation provides an opportunity to make mental health services more accessible to those who need them. Actual experience has shown that the majority of mid- to large-sized corporations eliminated outpatient and inpatient dollar limits but instituted visit or bed-day limits (Hay Group 1999).

Another important step on the road to parity was President Clinton's announcement in mid-1999 that a parity-level benefit would be implemented for 8.7 million beneficiaries of the Federal Employees Health Benefit Program (FEHB) beginning in calendar year 2001.[4] In doing so, the President noted, "We must make it clear once and for all: mental illness is no different from physical illness—and our nation's health plans should provide both with the same quality coverage." Research findings contained in the previous NAMHC reports contributed to the decision by the Office of Personnel Management (OPM) to recommend that such a step was financially feasible.

The feasibility of expanding mental health benefits to parity levels without dramatically raising costs has gained increasing acceptance among policymakers over the course of the Workgroup's reports. This is due in part to the containment of costs by managed care organizations. In response, the impact of managed care on the accessibility and quality of mental health care is a continuing source of attention and concern. As elaborated in this report, efforts are intensifying to develop uniform measures of quality for use in administration and research, and to find cost-effective ways to obtain data essential for evaluating quality in mental health services. However, these developments are still, for the most part, at an early stage.

The interactions of cost, quality, and access to mental health care under various conditions of parity and managed care have been the primary foci of the three prior NAMHC reports. These interactions are also at the heart of this report, which builds upon the growing experience of public and private mental health care systems with parity and managed care. The NAMHC Parity Workgroup has both stimulated and benefited from studies in progressively larger populations. These new data provide an increasingly reliable research base for future policy projections and decisions.

II. STATE PARITY LEGISLATION: CURRENT STATUS (1991-2000)

A. Background

Prior to 1996, only five States had successfully passed parity legislation. The passage of the federal 1996 Mental Health Parity Act gave significant momentum to this movement. After 1996, the number of bills introduced increased dramatically, with 26 additional States ultimately passing mental health parity. However, State parity laws are not homogenous, and most offer more benefits than the 1996 MHPA. In addition, the Federal Employee Health Benefits Program and five State-employee health programs (Ohio, North Carolina, Texas, Indiana, and Massachusetts) have initiated parity. The brief overview below of the current status of parity across the States indicates that the concept of parity is gaining widespread acceptance.

B. Recent Analyses

Scheffler and Gitterman (2000a) found significant statutory variation in how States regulate mental health insurance parity in the United States. That variation can be classified along six dimensions: type of mental health mandate; definition of mental illness; coverage of substance abuse; terms and conditions; and small-employer and cost-increase exemptions (see Appendix D, Table II).[5] The investigators also found significant differences in how States define "mental illness." They may use a broad-based definition[6] or definitions based on serious mental illness, on biologically based mental illness, or mental illness as defined by the health plan (see Appendix D, Tables IA-ID).

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[4] The FEHB parity-level benefits include coverage for substance use disorders. Although the current report focuses on parity for mental health, coverage for substance use disorders is an important issue, especially since many people with mental illness have comorbid substance use disorders.

[5] Note that in Appendix E, Tables IA-D focus on how States define mental illness under parity legislation, while Table II focuses on differences among State policies regarding parity.

[6] Broad-based coverage was defined to include all mental disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual (4 1h edition) and/or the mental disorders in the World Health Organization's International Classification of Disease.

As of May 15, 2000, 31 State legislatures have enacted mental health parity statutes (10 State legislatures passed parity statutes in 1999). Before the 1996 federal Mental Health Parity Act (MHPA), only five State legislatures had enacted parity statutes: Maryland (1994), New Hampshire (1994), Rhode Island (1994), Maine (1995), and Minnesota (1995).

After the 1996 MPHA, 26 State legislatures enacted mental health parity statutes between 1997 and May 2000: in 1997, six States (Arkansas, Colorado, Connecticut, Missouri, Texas, Vermont); in 1998, five States (Delaware, Georgia, Pennsylvania, South Dakota, Tennessee); and in 1999, 10 States (California, Hawaii, Indiana, Louisiana, Montana, Nebraska, Nevada, New Jersey, Oklahoma, Virginia). In 1999, two States revisited and broadened their original parity statute: Connecticut and Missouri. The 1999 legislative session recorded the greatest number of parity enactments during any single year during the 1990s. In 2000, five States enacted parity requirements (Alabama, Kentucky, Massachusetts, New Mexico, Utah) by early May.

Following the 1996 MHPA, 14 States also enacted statutes to match the federal parity statute including: in 1997, Alaska, Arizona, Delaware, Indiana, Kansas, Louisiana, Montana, Nevada, North Carolina, South Carolina, Tennessee, and West Virginia; and in 1998, Florida and New Mexico. Of the 14, seven States matched the federal statute in 1997 or 1998, and then opted to have a "stronger' State parity statute: Delaware (1998), Indiana (1999), Louisiana (1999), Montana (1999), Nevada (1999), New Mexico (2000) and Tennessee (1998). In addition, five States included mental health parity for their State employees: Ohio (1990), Texas (1991), North Carolina (1991), Massachusetts (1994), and Indiana (1997).

A preliminary econometric analysis by the same investigators (Scheffler and Gitterman 2000b) revealed a number of factors that influence the likelihood of passage of State parity legislation. They found that economic factors are important in influencing a State's decision to enact mental health parity. A State is more likely to enact mental health parity if it has higher levels of per-capita mental health spending; a higher proportion of the population under managed care; a higher level of mandated health benefits; and higher levels of education. Conversely, States with a higher percentage of small business firms are less likely to enact mental health parity. In an earlier study, Sturm and Pacula (1999) found that States with below-average mental health care utilization were more likely than other States to enact State parity legislation for mental health insurance.

III. UPDATE ON COST OF PARITY FOR ADULTS AND CHILDREN

A. Background

The Senate Appropriations Committee's data requests to the NAMHC reflect a continuing concern about the potential costs and consequences of implementing mental health parity. In response, the NAMHC Parity Workgroup, assisted by staff of NIMH and other federal agencies, as well as nonfederal consultants (see Appendix B), has provided systematic analyses of empirical data and economic models to clarify the costs of implementing such benefits (see National Advisory Mental Health Council 1998).[7] This report presents findings on the cost of parity from three types of studies: 1) predictions based on an updated simulation model; 2) an empirical case study using a pre-post parity design; and 3) other studies based on State-level data sets. The findings for both adults and children are summarized below.

B. Predictions Based on an Updated Simulation Model

Actuarial and economic forecasting models used to predict the differential cost of parity for mental health coverage under private insurance have continued to evolve, although their role is gradually being supplanted by empirical data from evaluations of actual State or company parity experience. Major improvements have been made in the data used to create a baseline for making projections. In addition changes created by managed care have been incorporated into the models used to project costs.

In May 1996, the Congressional Budget Office (CBO) issued a report entitled CBO's Estimates of the Impact on Employers of the Mental Health Parity Amend-

[7] Note that the proprietary data in this report on managed care costs, utilization, and quality derive from a small number of managed behavioral health care companies, without whose cooperation this report could not have been written. However, the reliance of the NAMHC parity workgroup on these data sources may have introduced an unavoidable bias: Managed care companies willing to share their data with federal researchers are not necessarily representative of the industry at large. They may provide better funding for mental health benefits and data systems, and be more thorough in their record keeping.

ment in H.R. 3103.[8] The CBO provided its own analysis predicting that the cost increases of total health benefits associated with mental health parity benefits in a pure indemnity (fee-for-service) plan would be 5.3 percent, with the aggregate estimate lowered to a 4 percent increase to reflect the influence of managed behavior health care plans on the market (Congressional Budget Office 1996). In a subsequent review of multiple estimates of mental health parity costs, Sing and colleagues (1998), based on Hay Group models, lowered the overall parity cost estimate to a 3.6 percent increase of total health benefits.

The NAMHC parity workgroup recently asked the Hay Group to update its simulation model for estimating the average annual premium increase with the implementation of parity. Using this new model and standard assumptions (see Appendix D that take into consideration the impact of managed care on baseline cost data led to a further reduction of the previously predicted cost increase with parity—from 3.6 percent to 1.4 percent of total health benefits. This recent estimate is based on using new data in the Hay model, including actuarial data from the Federal Employees Health Benefit Program, complemented by cost and utilization data from several large managed behavioral health care companies as well as the experience of a large State employees health plan (described in Section III of this report).[9] Nevertheless, even models such as the newest one developed by the Hay Group may overerestimate the cost of parity because they do not account adequately for many of the recent changes in the mental health care delivery system.

Research on interactions between managed care and mental health services points to "disconnects" between empirical research on managed care and the structure of models projecting costs. New findings in several key areas of study have not yet been incorporated into projection models. These include: 1) the response of managed care to changes in budgets and benefits; 2) the impact of managed care on demand responses to changes in benefits; and 3) the impact of managed behavioral health care carve-outs above and beyond existing managed care arrangements.

Nearly all current projection models adjust the level of predicted costs under a given benefit design according to the type of managed care arrangement within which the benefit is administered. For example, cost-reduction parameters are specified for various types of managed care arrangements (e.g., health maintenance organizations (HMOs), preferred-provider organizations (PPO), and point-of-service (POS) plans). Although these parameters are assumed to be fixed at levels estimated in the research literature, they may vary depending on the benefit design, the available budget for mental health, and other management responses (Huskamp 1999; Brisson et al. 1999). Current forecasting models do not take into account the evidence that management responds to budgets and benefits.

Most projection models continue to rely on estimates of demand response to copayment levels that are derived from the RAND Health Insurance Experiment (Wells et al. 1992). Those estimates are based on unmanaged fee-for-service indemnity arrangements. Research has shown repeatedly that the impact of management dominates the impact of benefit design. More specifically, managed care has led to reduced use of hospital care for any given insurance benefit arrangement. These findings suggest that both admissions and duration of hospital stays respond differently to insurance coverage in the presence of managed care (Ma and McGuire 1998; Goldman et al. 1998).

Similarly on the outpatient side, current evidence suggests that demand response to copayment levels is different under managed care than in the context of fee-for service plans. Some actuarial models, such as the updated Hay Group (2000) model, have recently begun to offer some sensitivity analysis to differing assumptions.a bout demand response for outpatient mental health care. Preliminary results from the sensitivity analysis indicate that different assumptions about the demand/consumer response for outpatient mental health care have minimal impact on the cost increase under parity.

Finally, projection models view the cost-control potential of health plans as depending entirely on the general model of care (e.g., HMO, PPO). Thus, an HMO that carves out its mental health care to a specialty vendor under a capitated premium is treated the same way analytically as an HMO with a fee-for-service network of providers and no carve-out. Recent research suggests that the use of specialty vendors within a general model of managed care will yield additional costs savings (Brisson et al. 1999; Sturm et al. 1998).

Hence, even with the improved empirical base of the recent Hay Group model, forecasting models that project mental health costs under private insurance lag be-

[8] H.R. 3103 was an earlier full-parity amendment consistent with the Senate Parity Bill sponsored at the time by Senators Domenici and Wellstone.

[9] The assumptions of this model are described in Appendix D.

hind the existing base of knowledge about modern mental health care delivery. (Both the rapid pace of research advances and the difficulty of incorporating such findings into forecasting models contribute to this lag.) Sensitivity analyses of forecasts using a range of assumptions about management, demand response, and organizational structure of markets are therefore needed to understand more fully the likely consequences of parity initiatives. However, as more results from State and large employer parity experiences are being published, the need to use projection models to predict the cost of parity becomes less critical.

C. Cost Impact of Parity under Managed Care: Case Study Based on Pro/Post Parity Design

A very recent analysis requested by the NAMHC parity workgroup (Zuvekas et al. 2000) examined the actual effects of a State mental health parity mandate (combined with "carve-out" managed care) on costs, utilization, and access for a large employer group (over 150,000 employees) subject to parity. The 4-year study extended from 1 year before parity to 3 years after parity was implemented. Overall, the study demonstrated that, compared with the pre-parity period, per-member costs were halved by the third year of parity, while the proportion of the population receiving some mental health services increased (from less than 5 percent to more than 7 percent),

What accounts for the cost reductions associated with parity combined with carve-out management? Although per-member costs declined only modestly (about 9 percent) between Year 1 and Year 4 for employees and their spouses, plan costs declined dramatically (by 75 percent) for dependents (especially for their inpatient treatment-see Subsection D, below). In fact, children and adolescents accounted for more than 90 percent of the overall cost decline. Increases in outpatient use and costs were offset by substantial declines in inpatient costs, by a factor of 4 or 5 to 1. (Most of the overall increases in outpatient costs came from an increase in the number of people receiving outpatient treatment.) Three-quarters of the declines in inpatient costs stemmed from reduced lengths of stay; decreases in inpatient admissions and per them costs account for the rest of the decline.

This case study also compared the experience of the large-employer group to other, smaller groups who were covered by the same insurance carrier but not subject to the parity benefit. These groups experienced increases in costs over the same period, suggesting that the large decrease in costs observed in the large-employer group was not simply an artifact of a general trend over time.

D. Costs and Coverage for Children

Background:

The need for better mental health services for children and adolescents is widely recognized. As researchers have often observed, "most children and adolescents who need mental health/substance abuse (MH/SA) services do not receive them" (Burns et al. 1999). However, during the mid-1990s, employment-based health insurance for children increased (Fronstin 1999). A growing amount of research has been clarifying how improved coverage combined with parity and managed care affects the cost and use of mental health services for children and adolescents.

Case Study 1: Single State Pre and Post

Parity The study by Zuvekas and colleagues (2000) described in Section IIIC showed that, in the experience of one large State, access to specialty mental health services increased by 50 percent for children and adolescents (as it did for adults) under parity with carve-out managed care. But, as noted above, the costs for children declined much more than they did for adults (75 percent for children vs. about 9 percent for adults) with 6- to 7-year-olds accounting for most of the decline. Because of very high inpatient utilization among children and adolescents in the large-employer group prior to parity, carve-out management was able to effectively reduce costs, despite improved benefits, while still increasing overall access. The same level of cost reductions might not necessarily be expected with other populations when simultaneously introducing parity and more intensive managed care; however, the experience described for the employees and their spouses suggests that costs would not dramatically increase.

Case Study 2: Multiple States

An analysis of the impact of parity legislation on the use and cost of mental health services for children and adolescents in 12 States was prepared by Cuffel and colleagues (I 999a). Adolescents have had relatively high mental health costs, primarily because of their use of inpatient care. This study revealed that parity legislation has widely varied effects on the use and cost of mental health services for adolescents across States. In some, such as Minnesota and Rhode Island, the increased benefits were associated with increases in costs, while in others, such as Colorado, the greatest decreases in cost and utilization after parity occurred among adolescent populations. These findings generally suggest that cost reductions for children and

adolescents under parity legislation stem primarily from reduction of inpatient services.

In both case studies, the decline in cost for children reflects a reduction in inpatient care, although outpatient use increased. It is not clear if this decrease in inpatient use is good or bad for adolescents. If appropriate outpatient services are available it may be a positive shift. However, the impact of such changes on the long-term mental health of children remains to be determined.

IV. ACCESS AND QUALITY UNDER PARITY

A. Background

By using various cost-control methods, managed behavioral health care has made it possible to offer expanded parity-level benefits without dramatic cost increases. However, those same controls are also sufficiently powerful to prevent access to mental health services. During the last 2 years, more data sets became available for evaluating access and refining its measurement. While researchers were initially only able to measure the probability of any mental health use in a given year, they can now also identify the intensity (volume) of access. In addition, a very recent study was able to differentiate between the population with severe mental illness (SMI) and the non-SMI population while evaluating access to care.

B. Case Studies

Case Study 1:

Concerns that cost containment and price competition among managed care companies might have unduly restricted access to specialty treatment led the NAMHC Parity Workgroup to request a preliminary study to examine the relationship between insurance companies' expenditures on mental health (measured by cost per member per month, PMPM) and the probability of receiving any specialty mental health treatment. The analysis indicates that, in general, access to specialty treatment decreases as mental health expenditures fall (Weissman et al. 2000).

Case Study 2:

The pre- and post-parity study described in Subsection III C (Zuvekas et al. 2000) provides extensive data on the impact of parity and carve-out managed care on access to and use of inpatient and outpatient mental health services by adults and children. Overall treated prevalence (for employees, spouses, and dependents) rose from 4.9 percent pre-parity (Year 1 of the study) to 7.3 percent after 3 years of parity (Year 4).

As noted earlier, this case study also compared the experience of the large-employer group to other smaller groups who were not subject to the parity benefit. Treated prevalence also increased in these smaller groups over the same period, suggesting that factors other than parity and carve-out management may have contributed to better access to services. However, it is also clear that parity and carve-out management did not lead to reduced access at the same time that costs were dramatically reduced.

Inpatient Admissions: Between Year 1 and Year 4 of the Zuvekas et al. study, inpatient admissions for employees and their spouses rose by a little over one quarter. However, for dependents, inpatient admissions fell 40 percent overall, with admissions down 65 percent for 6- to 12-year-olds and down 45 percent for 13- to 17-year-olds, while admissions rose slightly for dependents 18 and older.

During the same period the average number of inpatient nights decreased substantially for employees from 83 nights per 1,000 enrollees to 47 nights, and from 98 nights to 71 for spouses. Among children and adolescents, the number of inpatient nights decreased by 80 percent, with most decreases occurring among 6- to 17-year-olds. The average length of stay for these dependents fell from more than 30 nights per admission to about 10 nights per admission.

Although overall inpatient admissions for dependents, employees, and spouses fell slightly with parity (8 percent), the number of inpatient nights was reduced almost 70 percent. As noted above, dependents experienced the most dramatic changes. In the pre-parity period, 77 percent of dependents receiving inpatient treatment during the year spent more than 30 nights in the hospital, and 61 percent spent more than 60 nights. By the third year of parity, 52 percent of dependents receiving inpatient treatment spent more than 30 nights during the year as inpatients, and only 34 percent spent more than 60 nights. As noted in Section III, it is unclear if the decrease in inpatient use has a positive or negative impact, especially since outpatient use increased (see below). The long-term effect on, mental health remains to be determined.

Outpatient Utilization: Overall, both the proportion of enrollees with any outpatient use and number of outpatient visits per 1000 increased by 50 percent under parity. Dependents were less likely than employees or spouses to use outpatient

mental health and substance abuse services; they also tended, to have slightly fewer visits when they did use them. In general, although a greater proportion of enrollees were using mental health services after parity, the mean number of visits for those with any use remained virtually unchanged.

C. Studies Based on National Data Sets

In theory, implementing parity for mental health can reduce financial barriers to access to mental health care (Rupp and Lapsley 2000). Research based on national data sets confirms that more people have access to mental health care under parity, but there is not necessarily more use per individual (Sturm and Sherbourne 2000). Another national study, which examined how parity affects the use of mental health services by people in poor mental health vs. those not in poor mental health, revealed a small increase in number of visits among the former group (Sturm and Wells 2000). Despite some limitations in the generalizability of this study, it suggests that even limited reductions in co-insurance rates and deductibles can increase access for those in greatest need for mental health services.

V. DEVELOPMENT OF OUTCOME MEASURES OF QUALITY

A. Background

As noted in previous NAMHC reports on parity (National Advisory Mental Health Council 1998), the ability to measure the quality of health and mental health services is crucial for achieving the real intent of parity (i.e., providing the best and most appropriate services for those who need care). Various efforts have been launched, ranging from clinical measures for specific illnesses applied at the individual level to global performance measures applied to the health care system. Although the ability to measure quality has improved in recent years, there is still a long way to go (Dickey et al. 1998). Below we discuss recent developments in this area. Although no current data reveal the impact of parity on quality, these efforts should make it possible as data become available for care under parity.

B. Recent Developments

There are many ways to measure quality, but most are based on a model outlined by Donabedian many decades ago (Donabedian 1966). This model separates quality into three domains: structure, process, and outcome. Most current measures use some aspect of each of these, although the most popular is outcome assessment. Newer measures have expanded to incorporate other aspects, such as access to specific health services, and to include a more comprehensive view of the health system as well as education and caregiver support. Recently there have been efforts to move beyond simply measuring aspects such as structure and process to determine ways to reduce variation in health care by ensuring provider adherence to "evidence-based" guidelines.

Earlier studies showed that the quality of care for mental illnesses is not often good, especially in the general medical sector (Wells 1994; Wells et al. 1994). However, even in the specialty sector there are quality problems, as shown by recent reports from the Schizophrenia Patient Outcomes Research Team (Lehman and Steinwachs 1998). Although some earlier studies raised concerns about the quality of mental health care in managed care settings, there are no consistent data to indicate that managed care settings are any less likely than non-managed care settings to deliver appropriate treatment services (Durham 1998).

No currently available quality measures provide all the answers that consumers, providers, employers, and policymakers want. Some, such as the currently popular Health Plan Employer Data and Information Set (HEDIS) measures are not sufficient in the mental health area (Druss and Rosenheck 1997). In addition, outcomes of health care may be affected by factors that are not under the control of the medical system, or their relevance to a particular treatment may not become apparent for years. Thus, it is crucial to be able to link what is done in a particular patient encounter to the ultimate impact of that intervention. One way to do this is to show through research which interventions work for particular illnesses in specific populations. This is the basis for what is called "evidence-based practice."

The National Institute of Mental Health recently launched several major clinical treatment trials that will determine the effectiveness of treatment interventions in community populations with various mental illnesses. These studies will provide evidence about which interventions are best for the varied populations seen in everyday community practice. The first trials are in bipolar disorder, schizophrenia, depression in adolescents, and treatment-resistant depression in adults. Future studies will focus on other major mental illnesses.

Even with adequate measures, it is essential to have access to data that can be used to assess the quality of care delivered. This requires that a variety of data sources, such as clinical and survey data, be available. For example, information on

access to care can be obtained through surveys of consumers, but use of specific services is best determined through administrative databases. The need for these different sources of information presents a multitude of feasibility problems, however. Population surveys are often costly and require a great deal of effort to enlist a representative sample, while medical records and administrative data raise confidentiality concerns.

Because many of the factors that affect health are social and their relationship to health status is unclear, more research is needed at the interface between social sciences and clinical treatment. Acting without such data, or on the bases of imperfect data, could increase costs, disenfranchise groups who have special needs, and even put excellent health plans out of business.

Even with appropriate measures of quality and the ability to put them into place, interventions need to be developed that actually improve the quality of mental health care in places where it is now not optimal. Efforts to improve quality have focused on regulation, competition, quality-improvement programs, and economic incentives (Chassin 1997). Clearly, no single approach is sufficient; multiple approaches are needed. For example, regulation can set the groundwork for what is expected and make it possible to collect data that could be used to formulate risk adjustment. Competition is a powerful tool, but without valid measures of quality, the wrong factors may form the basis for competition among plans. Thus, consumers and health plans may segregate themselves to take advantage of the most positive results that relate to them. This might improve some specific areas of health care but might result in poorer general health care. Financial incentives can certainly influence what care is delivered, but it is unclear how much impact they have on quality and how to use them to improve the quality of care. A number of quality-improvement programs have been tried, and some recent evidence suggests that it is possible to improve the quality of care without major efforts (Wells et al. 2000). However, it still is unclear what programs will work and what other incentives will be needed to ensure that they last.

Current efforts are focused on finding ways to ensure that providers and consumers use the treatments that are considered best. We need to understand how providers, consumers, and systems will change their behavior to ensure that the best care is delivered and used. The NIMH is currently encouraging research that seeks to address these issues.

VI. WORKPLACE ISSUES

A. Background

Comprehensive analyses of the impact in the workplace (including employer concerns) of broadened mental health coverage under parity need to take into account parity's effect on the costs of general health care, and costs of disability and work productivity. Potential shifts of employees with mental illness into primary care to obtain mental health treatment, changes in workplace performance and attendance, and movement of workers between the employment and disability rolls are of particular interest to employers. No data are available on the impact of parity in these areas. However, previous research discussed below provides some insight into the potential effect of providing expanded mental health services under parity.

B. Indirect Effects of Mental Health Care on General Medical Care Costs

The interactions of somatic and psychological factors in health and illness—and their impact on health care use and costs—are gaining increasing recognition in a climate of greater management and cost control. There is widespread agreement that people with mental illness are high users of general medical services. For example, people diagnosed with depression have nearly twice the annual health care costs of those without depression, while those with somatization disorder have nine times greater annual health care costs than those without the disorder (Simon et al. 1995). There has been considerable interest in the effect of providing mental health and substance abuse treatment on the use and cost of general medical care.

In the classic research review and meta-analysis of how mental health care affects medical care costs (Mumford et al. 1984), most of the 58 studies under review demonstrated a medical cost offset, that is, a compensatory reduction in the cost of general health services, usually resulting from provision of short-term psychotherapy or supportive counseling. But many of the studies were difficult to interpret because of methodological flaws, such as lack of randomization or of a well-matched comparison group.

Two studies that used random assignment examined the effect of providing psychiatric consultation to primary care physicians for people with somatization disorder or somatization syndrome (Smith et al. 1986; Simon et al. 1995) Both studies

demonstrated reductions in health care expenditures (53 percent and 33 percent respectively) for the two illness groups.

Zhang and colleagues (1999) followed 435 people with depression over a 1 -year period. Among those receiving depression treatment, individuals treated in the mental health sector had significantly higher depression treatment costs and significantly lower lost earnings than those treated in the primary care sector. The investigators concluded that the annual net economic costs are lower for people treated within the mental health sector than for those treated by primary care providers.

Concern has been expressed in the field that restricting access to specialty mental health services might shift the cost of caring for the mentally ill into the general health system. This concern is based in part on findings of cost shifting to the general health system, such as that identified by Rosenheck and colleagues (1999) described in Section C below. However, a recent study of the transition of a large employer from an unmanaged indemnity plan to a managed behavioral health carveout did not show any evidence of cost shifting (Cuffel et al. I 999b). This study compared the use and cost of behavioral health care and medical care services during a 2-year period before the carve-out and 3 years afterward. Medical care costs decreased for those using behavioral health care services during a period when such costs were generally increasing.

England (1999) has proposed that medical cost offset data could be very valuable for identifying people who are underserved and for developing better coordination of medical and mental health care. She underscores the importance of linking employer databases of aggregate data on health, mental health, disability, workers' compensation and employee absenteeism to comprehend fully how changes in mental health coverage and policy affect the system as a whole, rather than the mental health specialty sector alone. It is important to remember, however, that the idea of a medical cost offset presents enormous conceptual and methodological challenges that make it difficult to study.

C. Indirect Effects of Mental Health Care on Disability

The World Health Organization (WHO) Report on the Global Burden of Disease (Murray and Lopez 1996) highlights the substantial impact of disability resulting from several major mental and addictive disorders—especially major depressive disorder-compared to physical disorders. Among the 10 leading causes of disability worldwide, four are mental disorders, and unipolar major depression leads the entire list. It is well known from the clinical and disability literatures that severe mental disorders tend to have earlier ages of onset and are more persistent than many other disabling conditions; thus they tend to result in longer periods of disability. Even among those able to work, the severity of illness affects both productivity at work and the ability to tolerate the stress of the workplace. However, current treatments for depression and other mental illnesses offer appreciable benefits for workers and their employers. For example, the effectiveness of treatments for depression in improving work performance, satisfaction, and work relations has been convincingly demonstrated in meta-analyses of several randomized clinical trials (Mintz 1992).

The economic impact of effective treatment can be considerable, given the high toll of disability exacted by certain mental disorders. Kessler and colleagues (1999) recently estimated the short-term work disability associated with a diagnosis of major depression over a 1-month period, based on an analysis of two national surveys (the National Comorbidity Survey and the Midlife Development in the United States Survey). Such short-term work disability is much more prevalent among workers with major depression (affecting 37 to 48 percent) than among those without depression (affecting 17 to 21 percent). Within a 30-day period, workers with depression experienced between 1.5 and 3.2 more short-term work-disability days than workers without depression. This differential represented "a salary-equivalent productivity loss averaging between $182 and $395 [during the 30-day period]." The researchers showed that this amount was nearly comparable to the direct costs of treatment of depression for that period of time, thus providing support for the cost-effectiveness to employers of providing mental health treatment. [10]

How does managed care affect the workplace and the work-related benefits of treatment? In a recent Yale study, Rosenheck and colleagues (1999) examined the impact of managed care (not under parity) on employees of a large national corporation. During the 3-year study period mental health expenditures decreased, due to a large decrease in the use of specialty mental health services. At the same time,

[10] This study only examined the cost of short-term work disability for employed persons; it did not include the costs to employers of long-term depression-related disability for those no longer in the work force. Thus, it underestimates the total disability impact associated with this illness

however, there was greater employee absenteeism and poorer work performance; in addition, increased general health costs offset any savings in mental health specialty costs among users of mental health services.

Researchers at Johns Hopkins University (Salkever et al. 2000) have found that in general, having greater access to outpatient specialty care and increased mental health coverage reduces the number of mental health disability claims. Plans with the highest financial barriers (first dollar costs and coinsurance) experienced more psychiatric disability claims. By contrast, front-line disability management (e.g., providing alternative employment and offering Employee Assistance Program services) was associated with reduced numbers of claims, as was having greater organizational access to specialty care through carve-outs.

VII. PUBLIC-PRIVATE SECTOR INTERFACE

A. Background

Concern about parity's potential for shifting mental health care costs to the general medical sector is paralleled by concern about parity's potential to shift some expenditures for mental health/substance abuse care from the public sector to the private sector. The latter shift may lower overall mental health/substance abuse expenditures as a result of efficiency gains in the private sector, but higher private insurance premiums may also result. (Another potential shift of particular concern to people with severe mental illness is that from the private to the public sector due to exhaustion of private insurance benefits—especially for inpatient care.) Studies delineating differences in utilization and cost between the public and private sectors, as well as the effects of parity and managed care in encouraging cost shifting between the sectors are at an early stage of development. A few recent findings are reported here.

B. Single-State Case Studies

Case Study 1: Public-Private Sector Comparisons: Utilization and Expenditures

A 1-year study was recently conducted of utilization patterns and expenditures for a single managed care company providing mental health and addictive services to a State population of almost 2 million enrollees; of these, approximately 650,000 were in the public sector (Goldman H. et al. 2000). The study provides a more complete picture of a single State mental health system—in both private and public sectors—than previously available. Preliminary data from the study indicate that all service use (except rarely used and usually noncovered substance abuse services) is higher in the public sector than in the private sector. This difference does not seem to change dramatically when managed care is implemented in both the public and private sectors by the same managed behavioral health care company.

Case Study 2: Public-Private Sector Cost Shifting

A recent study using a longitudinal data source (pre-parity) from the mid-1 990s (containing individuals with private insurance who also use public-sector services, as well as privately insured individuals who do not use publicly financed services) is contributing to understanding interactions and cost shifting between the public and private mental health care systems (Siegel et al. 1997, 2000). Major findings of this case study indicate that during a year, only a small proportion (<1 percent) of those with private insurance directly shifted to the public sector; a larger proportion (<2.2 percent) of those with private insurance shifted to a mixture of private and public sector services.

During the first year of the study, the latter group had the highest costs within the private group. There is a high likelihood of remaining in the mixed private/public pay category; approximately 55 percent of people in that group remain in it over 2 years, and have consistently high costs. People who shift from private to public sector or to a mixture of public and private sectors tend to be dependents (with subsidized income) of employed individuals. This study demonstrates empirically that the public and private insurance sectors are not mutually exclusive, and individuals are not purely in one sector or the other. There is a small group of high-use, high-cost patients who are being financed by both sectors, and about 13 percent of them moved to the public sector after being in the mixed sector for 2 years.

VIII. KNOWLEDGE GAPS

Since the first NAMHC report on parity to the Senate Appropriations Committee, a substantial body of research knowledge has developed concerning the impact of parity on mental health care and its costs. However, many gaps in knowledge remain as the focus of inquiry shifts from the cost of parity to its short-term and long-term effects—in combination with managed care. These include:

What is the long-term effect on continued access to appropriate mental health services?

What is the impact on particularly vulnerable populations, such as children and adolescents, the elderly, the severely mentally ill, and traditionally underserved populations?

What is the effect on disability and work productivity in insured populations?

How is the quality of treatment affected?

What is the long-term impact on public mental health?

How do health care systems respond to parity?

What is the impact on the types of co-morbid problems seen in the general health care sector?

Both the implementation of a parity-level benefit in the Federal Employees Health Benefit plan in 2001 and the implementation of parity in 31 States offer unique opportunities to study many of these issues and build on a strong foundation of baseline data.

References

Burns BJ, Teasel SE, Schwartz M, Angold A, and Holzman, A (1999): Managed behavioral health care: A Medicaid carve-out for youth. Health Affairs 18 (5) 214-225.

Brisson AS et al. (1999): Changes in a MBHC carve-out: Impact on mental health spending and utilization. Working paper, Harvard University.

Chassin MR (1997): Assessing strategies for quality improvement. Health Affairs 16: 151-161.

Congressional Budget Office (May 1996): CBO's Estimates of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103, Congressional Budget Office memo, Mayl 3, 1996.

Cuffel BJ, Goldman W, and Schlesinger H (1 999b): Does managing behavioral health care services increase the cost of providing medical care? The Journal of Behavioral Health Services & Research 26 (4) 372-380.

Cuffel, BJ, McCulloch J and Goldman W (1999a): Behavioral health service use by children and adolescents in a managed behavioral health carve-out. Prepared for the National Institute of Mental Health by United Behavioral Health.

Dickey B, Hermann RC, and Eisen SV (1998): Assessing the quality of psychiatric care: Research methods and application in clinical practice. Harvard Review of Psychiatry 6 (2): 88-96.

Donabedian A (1966): Evaluating the quality of medical care. Milbank Memorial Fund Quarterly 44: 166-203.

Druss BG and Rosenheck R (1997): Evaluation of the HEDIS measure of behavioral health care quality, Psychiatric Services 48 (1): 71-75.

Durham, M (1998): Mental health and managed rare. Annual Review of Public Health 19: 493-505.

England MJ (1999): Capturing mental health cost offsets. Health Affairs 18(2), 91-3.

Fronstin P (1997): Employment-based health insurance for children: Why did coverage increase in the mid-1990s? Health Affairs 18 (5): 131-136.

Goldman H, Regier DA, Rupp A, Shade T, Beaudin C, Rana S, et al. (2000): Maryland case study of mental health services: Private and public patterns under parity (unpublished manuscript).

Goldman W, McCulloch J, and Sturm R (1998): Costs and use of mental health services before and after managed care. Health Affairs (March/April) 17(2) 40-52.

Hay Group (1999): Employer mental health coverage features and compliance with the Mental Health Parity Act. Hay Report for NIMH, June 1999.

Hay Group (2000): Mental Health Benefit Value Comparison MHBVC Version 2.0, March 14, 2000: Report Prepared for National Institute of Mental Health

Huskamp HA (1999): Episodes of mental health and substance abuse treatment under a managed behavioral health carve-out. Inquiry 36 (2)147-161.

Kessler RC, Barber C, Birnbaum HG, Frank RG, Greenberg PE, Rose RM, Simon GE, and Wang P (1999): Depression in the workplace: Effects on short-term disability, Health Affairs 18 (5), 163-171.

Lehman AF and Steinwachs DM (1998): Patterns of usual care for schizophrenia: Initial results from the schizophrenia PORT client survey. Schizophrenia Bulletin 24: 1-10.

Ma CT and McGuire TG (1998): Costs and incentives in a mental health carve-out Health Affairs 17(2), 53-69.

Mechanic, D and McAlpine D (1999): Mission unfulfilled: Potholes on the road to mental health parity. Health Affairs 18 (5), 17-21.

Mintz J, Mintz LI, Arruda MJ, and Hwang SS (1992): Treatments of depression and the functional capacity to work. Archives of General Psychiatry 49 (10): 761-768.

Mumford E, Schlesinger HJ, Glass GV, Patrick C, and Cuerdon T (1984): A new look at evidence about reduced cost of medical utilization following mental health treatment. American Journal of Psychiatry 14 (10) 1145-58.

Murray JL and Lopez, ADL (Eds.) (1996): The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020, Cambridge: Harvard University Press.

National Advisory Mental Health Council (1998): Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality. An Interim Report to Congress by the National Advisory Mental Health Council. NIH Publication No. 98-4322.

National Committee for Quality Assurance (1997): HEDIS 3.09: Narrative—What's in It and Why it Matters. Annapolis Junction, MDL NCQA. Volume 1.

Rosenheck R, Druss B, Stolar M, Leslie, D, and Sledge W (1999b): Effect of declining mental health service use on employees of a large corporation. Health Affairs 18 (5),193-203.

Rupp A and Lapsley H (2000): The challenges of meeting the unmet need for treatment: economic perspectives, in-Unmet Need In Psychiatry, (eds. Gavin Andrews and Scott Henderson), Cambridge University Press, pp. 119-131.

Salkever DS, Goldman H, Purushothaman M, and Shinogle J (2000): Disability management, employee health and fringe benefits and long-term disability claims for mental disorders: An empirical exploration, Milbank Quarterly (in Press).

Scheffler RM and Gitterman DP (2000a): A decade of mental health parity: The regulation of mental health insurance coverage in the United States, 1991-1999. A report to the National Institute of Mental Health and the National Advisory Mental Health Council February 1, 2000.

Scheffler RM and Gitterman DP (2000b): Executive summary of state parity legislation analysis: Preliminary results of regression analyses. A report to the National Institute of Mental Health and the National Advisory Mental Health Council February 1, 2000.

Siegel C, Samuels JA, Regier DA, Laska E, and Wanderling, J (1997): The impact of mental health parity legislation on health insurance premiums (unpublished manuscript).

Siegel, Samuels JA, Regier DA, Laska E, and Wanderling, J (2000): The impact of mental health parity legislation on health insurance premiums: Final report to NIMH.

Simon G, Ormel J, VonKorff M, and Barlow W (1995): Health care costs associated with depressive and anxiety disorders in primary care. American Journal of Psychiatry 152 (2): 352-357.

Sing M, Hill S, Smolkin S, and Heiser N (1998): The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits. Rockville, MD: US Department of Health and Human Services Publication No. SMA 98-3205.

Sturm R and Pacula R L (1999): State mental health parity legislation: Determination or cause of utilization differences? The RANP Corporation: Working Paper No. H-149, March 1999.

Sturm R, Goldman W, and McCulloch J (1998): Mental health and substance abuse parity: A case study of the Ohio State Employees Program. Journal of Mental Health Policy and Economics 1: 129-134.

Sturm R and Sherbourne CD (2000): Managed care and unmet need for mental health and substance abuse care in 1998. Psychiatric Services (February) 51 (2): 177.

Sturm R and Wells K (2000): Health Insurance May Be Improving - But Not for Individuals with Mental Illness, Health Administration Press/HSR/ 95:1 (April) Part 1, pp. 253-275

Weissman E, Pettigrew K, Sotsky S, and Regier DA (2000): The cost of access to mental health services in managed care. Psychiatric Services (in press).

Wells KB (1994): Depression in general medical settings. Psychosomatics 35 (3): 279-296.

Wells KB and Burnam A (2000): "FEHP Parity Implementation: Evaluation Questions and Some Design Options." (Presentation to RWJ Parity Conference March 3, 2000).

Wells KB, Burnam A, Rogers W, and Hays R (1992): The course of depression in adult outpatients: Results from the Medical Outcomes Study. Archives of General Psychiatfy 49 (10): 788-94.

Wells KB, Katon W, Rogers B, and Camp P (1994): Use of minor tranquilizers and antidepressant medications by depressed outpatients: Results from the medical outcomes study. American Journal of Psychiatiy,l 51 (5): 694-700.

Wells KB, Sherbourne C, Schoenbaum M, Duan N, Meredith L, et al. (2000): Impact of disseminating quality improvement programs for depression in managed primary care: A randomized controlled trial. Journal of the American Medical Association 283 (2): 212-220.

Zhang M, Rost KM, and Fortney JC (1999): Earnings changes for depressed individuals treated by mental health specialists. American Journal of Psychiatry 156: 108-114.

Zuvekas SH, Regier DR, Rae D, Rupp A, and Narrow W (2000): The differential impacts of mental health parity and managed care: Evidence from a large natural experiment. (working paper).

APPENDIX A:

Workgroup Charge from Senate Report No.105–300

"Research has provided clear evidence that mental illnesses are diagnosable, treatable, and real diseases affecting the brain. The Committee has recently received from the National Advisory Mental Health Council [NAMHC] the report requested in its fiscal year 1998 appropriations report and notes the impact of managed care on keeping costs of parity at a low level. The Committee requests that the NAMHC prepare an additional report on its findings from emerging health services research data from both the private and public sectors and submit it under the provisions of section 406g of the Public Health Service Act. Where possible, the report should address both employer direct costs, and the impact of indirect cost savings from successful treatment of employees. This report should, to the extent possible, also consider the costs and quality of coverage for children, and the development of outcome measures of quality for all mental health coverage."

APPENDIX B:
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APPENDIX D: Comparing Parity Cost Estimates Using Actuarial Models

The new NAMHC estimate of a 1.4 percent cost increase in total health insurance premiums due to parity is lower than previously reported estimates based on Hay Group actuarial models (all were of similar magnitude). Previous estimates include the 1996 Congressional Budget Office (CBO)/Congressional Research Service (CRS) 4.0 percent increase, the 1998 Substance Abuse and Mental Health Services Administration (SAMHSA) estimate of 3.6 percent, and estimates from the previous NAMHC report, as shown in the Table below. Because each of the Hay Group model-based estimates uses the same basic methodology it is important to understand what drives the latest estimate.

Table. Cost of Full Parity Estimates Based on Hay Group Actuarial Models

		Increase in Total Premium	
Estimate	Model Version*	FFS Plans	All Plans
CBO/CRS (1996)	HCBVC 6.5	5.3%	4.0%
NAMHC (1998)	MHBVC1.7	4% to 5%	<1 to 4%
SAMHSA (1998)	MHBVC1.7	5.0%	3.6%
NAMHC (2000)	MHBVC2.0	1.4%	1.4%

* Principal model for mental health/substance abuse cost estimates (separate model used to calculate non-mental health costs for HMOS in all but CBO/CRS study).

The different Hay Group models (HCBVC 6.5, MHBVC1.7, MHBVC2.0) work essentially the same way. The Hay Group uses actuarial methods to develop an expenditure grid, which represents the extent of medical, mental health, and substance abuse service use by plan enrollees if they paid nothing out of pocket (i.e., if the plan paid 100 percent). Combinations of induction factors (which measure how responsive enrollees are in reducing their health care use when faced with higher out-of-pocket costs) and management factors (which measure how costs are reduced with utilization review and other managed care practices) are then used to estimate how much care enrollees would use when faced with a particular set of copayments. Administrative loading factors are used to multiply these costs to determine the estimated premium for a particular health care benefit package.

The cost of a change in the health care benefit package, such as mental health parity, is simulated by first estimating the cost with existing benefits in the Hay model and then estimating the cost with the new benefits. All other assumptions are held constant (except, of course, for benefits). Because both baseline costs and benefits differ in fee-for-service (FFS), preferred-provider organization (PPO), point-of-service (POS), health maintenance organization (HMO), and managed behavioral carve-out plans, the Hay models were used to compute separate estimates of the cost of parity for these different types of health plans. The 1998 SAMHSA and the 2000 NAMHC estimates then combine these separate estimates (using assumptions about the distribution of enrollees across types of plans) to produce a single estimate of the total cost impact of mental health parity. The previous NAMHC (1998) report did not present a single cost estimate, but rather a range of estimates based on the different plan types. The CBO/CRS estimated a typical FFS plan and then made an ad hoc adjustment downwards to reflect managed care.

The major difference between the current NAMHC estimate of 1.4 percent and previous estimates appears to be driven by the evolution of the Hay Group model as it is updated to reflect changes in the underlying distributions of mental health and

health care expenditures. The most recent version of the Hay Group model (MHBVC2.0) assumes an average mental health and substance abuse cost per enrollee (with no out-of-pocket costs) that is fully *one-half* that of the Hay Group model used for the 1998 SAMHSA and the previous NAMHC report estimates, and *one-third* that of the model used for the 1996 CBO/CRS estimate (NAMHC calculations from Hay Group models). The most recent Hay Model incorporates new data from the FFS/PPO plans of the Federal Employees Health Benefit Program (FEHBP), several large managed behavioral health care companies, and the FFS plan of a large State employees health plan (described in Section III of this report). The experience of the FEHBP program, along with other evidence, suggests that mental health and substance abuse costs have declined substantially during the 1990s, mainly due to sharply reduced inpatient utilization even in FFS/PPO plans. Because mental health costs have declined, especially as a proportion of total health care costs, the estimated impact of a mental health parity benefit in terms of the increase in total premiums has correspondingly declined.

There are other much smaller differences in the assumptions used between current NAMHC estimate and previous estimates. The assumptions are discussed in more detail below, but in general these explain little of the differences between the estimates. (A useful companion to this discussion of the estimates is the report by Sing and Hill (1998) detailing the assumptions used to generate the 1998 SAMHSA estimates.) This is illustrated by the fact that when the NAMHC (2000) assumptions are applied to the previous version of the Hay Model (MHBVC1.7) used to produce the 1998 SAMHSA estimate, the estimated impact of parity is 3.7 percent instead of 1.4 percent (*preliminary* NAMHC calculations from the MHBVC1.7 model). That is, when the same assumptions are applied to mental health treatment patterns prevailing several years ago, the estimated cost of parity is 3.7 percent, but taking into account recent trends in mental health costs reduces the estimated cost of parity to a current level of 1.4 percent.

Other Differences in Basic Assumptions

Family vs. single premiums: The current NAMHC estimate is for singles only, while the other estimates represent the percent increase in total family premiums. Preliminary calculations using the new Hay model suggest that increase in total family premiums would be approximately 1.6 percent, a slight increase from the 1.4 percent for the single premiums.

Distribution of Health Plans: The 1998 SAMHSA and the current NAMHC estimates assume different distributions of types of health plans, but this difference has no effect on either estimate. That is, applying the 1998 SAMHSA distributions to the current NAMHC estimate produces the same estimate, and vice versa. (The 1998 SAMHSA estimate assumes a distribution in which 20 percent of plans are FFS, 30 percent PPO, 20 percent POS, and 30 percent HMO, compared to a distribution of 14 percent, 40 percent, 20 percent, and 26 percent respectively in the 2000 NAMHC estimate.) The CBO/CRS estimate contains an unknown adjustment for managed care plans from their base FFS estimate.

Carve-outs: The current 1.4 percent NAMHC estimate includes an adjustment that assumes that 20 percent of FFS, PPO and POS plans have carved out their mental health and substance abuse benefits. This 20 percent factor is the same for both the current and parity benefit cost estimates. Several surveys estimate that in at least 20 percent (KPMG Peat Marwick, Hay Group) of these types of plans among medium and large employers, the employer separately contracts (carves-out) with a managed behavioral health firm. This 20 percent is a conservative estimate of carve-out management since FFS, PPO, and POS health plans may themselves subcontract

(carve-out) behavioral benefits, but there are no good estimates of the extent of these indirect carve-outs. The 20 percent carve-out adjustment has a negligible impact on the current NAMHC estimate—without it the estimate is 1.5 percent—because the difference between cost increases in carve-out plans and non-HMO plans have decreased considerably. However, applying the 20 percent carve-out adjustment to the 1998 SAMHSA estimate would considerably reduce it from 3.6 percent to around 3.0 percent.

Benefits: All of the estimates use the same basic assumptions about existing mental health and substance abuse with one exception. The CBO/CRS estimates assumed that a $50,000 lifetime maximum applied to mental health benefits, while all the other estimates occurred after the federal parity legislation that removed this limit. There were slight differences across the different estimates in the assumed medical/surgical benefits, but these differences likely had little impact on any of the estimates.

Management Factors: The Hay Group models all incorporate a management factor to account for the effect of use of utilization review and other managed care techniques in reducing costs. The factors were, for the most part, the same across all of the estimates and the same factor was used to estimate both the cost under current benefits and under a parity benefit. The 1998 SAMHSA estimate includes a management factor for FFS, PPO, and POS plans that implies a reduction of 25 percent in mental health and substance abuse costs compared to unmanaged costs, but no reduction for HMO costs because the tighter management in HMOs are already reflected in the HMO expense grids. The current NAMHC estimate uses the same 25 percent management factor adjustment for FFS, PPO, POS, HMO and carve-out plans to estimate costs under current and under parity benefits. Preliminary NAMHC calculations suggest that if the 25 percent adjustment for HMOs and PPO is eliminated, the current NAMHC estimate of 1.4 percent overall increase in premium costs due to parity would change slightly to 1.5 percent.

Induction (Demand Response): All the estimates based on the Hay Group model use the same induction factors, which are derived from the RAND Health Insurance Experiment, with one small exception. The 1998 SAMHSA estimates used slightly lower induction factors for HMO plans. However, this makes little difference in the overall estimates.

Administrative Factors: The Hay Group model multiplies the base claims costs in their models by an administrative loading factor, which represent a fixed percentage of the total claims costs for administrative costs and profit (where applicable), to obtain the total premium cost. The current NAMHC estimate uses the same administrative factor of 1.11 for all types of health care plans (carve-outs, HMO, FFS, PPO, POS). The 1998 SAMHSA estimate used the same administrative factor of 1.11 for FFS, PPO, and POS plans but higher loading factors of 1.15 for medical/surgical expenses and 1.2 for behavioral coverage. However, because these administrative load factors multiply both the numerators and denominators, the effect of differing administrative load factors tends to be canceled out when examining changes in premium costs.

References:

Hay Group (1999): *Employer Mental Health Coverage Features and Compliance with the Mental Health Parity Act. Hay Report for NIMH, June 1999.* (unpublished).

KPMG Peat Marwick, *Health Benefits in 1997*, June 1997.

Sing M. and Hill S. (1998): *Predicted Premium Increases Due to Full and Partial Parity for Mental Health and Substance Abuse Insurance Benefits.* Report Submitted to the Substance Abuse and Mental Health Services Administration. Washington, DC: Mathematica Policy Research, Inc.

APPENDIX E:
States with Mental Health Parity Statutes

As of May 15, 2000, 31 States now prohibit discrimination in insurance and managed care coverage of mental illnesses:

Alabama
Arkansas
California
Colorado
Connecticut
Delaware
Georgia
Hawaii
Indiana
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Minnesota
Missouri
Montana
Nebraska
New Hampshire
New Mexico
New Jersey
New Mexico
North Carolina
Oklahoma
Rhode Island
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia

Source: Richard M. Scheffler, Daniel P. Gitterman, Marcia C. Peck, University of California, Berkeley, *The Political Economy of Mental Health Insurance in the United States*, NIMH grant (MH-18828-11).

TABLE IA: DEFINITION OF "BROAD-BASED" MENTAL ILLNESS IN STATE PARITY STATUTES

(Updated as of May 15, 2000)

"Broad-Based Coverage"	DSM-IV[1]	ICD[2]	DSM-IV and ICD
Alabama		X	
Arkansas			X
Georgia			X
Connecticut (99)	X[3]		
Kentucky			X[4]
Maryland[5]			
Missouri (97)	X		
Tennessee	X		
Utah	X[6]		
Vermont		X	

[1]DSM-IV includes disorders contained in the American Psychiatric Association's *Diagnostic and Statistical Manual*, fourth edition.

[2]ICD includes disorders contained in the World Health Organization's *International Classification of Disease*, latest edition (current edition is 10th edition).

[3] Connecticut includes coverage for all mental disorders in the most recent edition of the *DSM-IV* excluding mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the *DSM-IV*.

[4] Kentucky includes coverage for all disorders in the most recent edition of *the Diagnostic and Statistical Manual* or the *International Classification of Disease* but excludes coverage for conduct disorders (except ADHD), pervasive developmental disorder (except autism), learning disabilities, behavioral disorders, personality disorders, and mental retardation.

[5] Maryland parity statute covers "mental illness and emotional disorders" and is considered a broad-based statute. However, the statute does not specify DSM or ICD criteria.

[6] Utah includes coverage for all disorders in the most recent edition of *the Diagnostic and Statistical Manual* but excludes the following when diagnosed as the primary or substantial reason or need for treatment: marital or family problems; social, occupational, religious or other social maladjustment; conduct disorder; chronic adjustment disorder, psychosexual disorder; chronic organic brain syndrome; personality disorder; specific developmental disorder or learning disability; or mental retardation.

Source: Richard M. Scheffler, Daniel P. Gitterman, Marcia C. Peck, University of California, Berkeley, *The Political Economy of Mental Health Insurance in the United States*, NIMH grant (MH-18828-11).

TABLE IB: DEFINITION OF "SERIOUS MENTAL ILLNESS" IN PARITY STATUTES

(Updated as of May 15, 2000)

	Schizophrenia	Schizoaffective disorder	Bipolar disorder	Major depressive disorder	Obsessive-compulsive disorder	Panic disorder	Autism	Paranoia/psychotic	Delusional disorder	Child/adolescent depression	ADHD	Anorexia/bulimia/nervosa	Post-Traumatic Stress Disorder
NAMHC[1]	X	X	X	X	X	X	X						
California[2]	X	X	X	X	X	X	X			X[2]	X[2]	X	
Louisiana[3]	X	X	X	X	X	X	X					X	X
Nevada	X	X	X	X	X	X							
Penn.	X	X	X	X	X	X			X			X	
Delaware	X	X	X	X	X	X			X			X	
Texas (97)	X	X	X	X	X		X	X		X			
Montana	X	X	X	X	X	X	X						
Maine[4]	X		X	X	X	X	X	X					
Rhode Island	X	X	X	X	X				X				
Nebraska	X	X	X	X	X				X				
Oklahoma	X	X	X	X	X	X							
Hawaii	X	X	X										

[1]NAMHC: Definition as operationalized by National Advisory Mental Health Council (1993).

[2]Definition also includes serious emotional disturbances of a child, defined as a child who has one or more mental disorders included in the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance abuse disorder or developmental disorder. In addition, child must meet certain functional criteria (see text for details). Theoretically, all *DSM-IV* disorders are covered for children under 18 who meet the above criteria. ADHD is covered when diagnosed before age 18, as is true in the majority of cases.

[3]Definition also includes intermittent explosive disorder, psychosis NOS under 17, Rett's disorder, and Asperger's disorder.

[4]Maine statute does not specifically use the term "serious mental illness," but the disorders covered fit best with this classification.

Source: Richard M Scheffler, Daniel P. Gitterman, Marcia C. Peck, University of California, Berkeley, *The Political Economy of Mental Health Insurance in the United States*, NIMH grant (MH-18828-11)

TABLE IC: DEFINITION OF "BIOLOGICALLY-BASED" MENTAL ILLNESS IN STATE PARITY STATUTES

(Updated as of May 15, 2000)

	Schizophrenia	Schizoaffective disorder	Bipolar disorder	Major depressive disorder	Obsessive-compulsive	Panic disorder	Autism	Paranoia/psychotic	Delusional disorder	Childhood depression	ADHD	Anorexia/bulimia nervosa	Post-Traumatic Stress Disorder
Literature[1]	X	X	X	X	X	X	X	X		X	X	X	X
Massachusetts	X	X	X	X	X	X		X		X[2]	X[2]		
Missouri (99)[3]	X	X	X	X	X	X		X		X		X	X
Virginia	X	X	X	X	X	X	X	X			X		
Connecticut (97)	X	X	X	X	X	X	X	X					
New Jersey	X	X	X	X	X	X	X	X					
New Hampshire	X	X	X	X	X	X	X	X					
Colorado	X	X	X	X	X	X							
South Dakota	X	[4]	X	X	X	[4]		X[5]					

[1]Literature indicates what disorders recent medical literature claims as having possible genetic basis. List also includes Tourette's and conduct disorder.

[2]Massachusetts statute also provides nondiscriminatory coverage for delirium and dementia, affective disorders, and any biologically based mental disorders appearing in the *DSM* that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance. Coverage also includes non-biologically based mental disorders for children and adolescents, defined as persons under age 19 having disorders described in *DSM-IV* that substantially interfere with or limit functioning and social interactions (see text for details). Medically necessary care is mandated for the diagnosis and treatment of all other mental disorders in the *DSM-IV*.

[3]Missouri statute does not specifically use the term "biologically based," but the disorders covered fit best with this classification. Missouri statute also covers other affective psychoses.

[4]Removed by H 1264 (1999).

[5]Added by H 1264 (1999).

Source: Richard M. Scheffler, Daniel P. Gitterman, Marcia C. Peck, University of California, Berkeley, *The Political Economy of Mental Health Insurance in the United States*, NIMH grant (MH-18828-11).

TABLE ID: HEALTH PLANS SET THE DEFINITION OF MENTAL ILLNESS COVERAGE IN STATE PARITY STATUTES[1]

(Updated as of May 15, 2000)

State	Individual Plan[2]
Indiana (99)	X
Minnesota	X
New Mexico	X

[1] Does not include State statutes that match the federal 1996 MHPA or cover State employees only.

[2] Individual plan indicates determined by individual health plans, usually subject to approval by the respective Departments of Insurance.

Source: Richard M. Scheffler, Daniel P. Gitterman, Marcia C. Peck, University of California, Berkeley, *The Political Economy of Mental Health Insurance in the United States*, NIMH grant (MH-18828-11).

TABLE II: VARIATION IN STATE MENTAL HEALTH PARITY STATUTES

(Updated as of May 15, 2000)

State	Year Enacted	MH Benefit Mandate[a]	Broad Definition Mental Illness[b]	Covers Substance Abuse[c]	Set = terms and conditions[d]	Covers individual and group plans[e]	Small employer exempt[f]	Cost Exempt[g]
Federal MHPA	96	M(ifoff)	X				X	X
Alabama	2000	MO	X		X		X	
Arkansas	97	MB	X	X (opt out)[1]	X		X	X
California	99	MB			X	X		
Colorado	97	MB			X			
Connecticut (A)	97	MB			X	X		
Connecticut (B)	99	MB	X	X	X	X		
Delaware	98	MB			X	X		
Georgia	98	MO	X	X	X-group plans	X		
Hawaii	99	MB			X	X	X	
Indiana (A)	97	M(ifoff)			X	SE only[1]		X
Indiana (B)	99	M(ifoff)			X	X	X	X[2]
Kentucky	2000	M(ifoff)	X	X	X		X	
Louisiana	99	MB MO[3]	X (MO only)					
Maine	95	MB MO[4]			X	X (MO only)	X	
Maryland	94	MB	X	X		X		
Mass (A)	93	MB	X	X		SE only[1]		
Mass (B)	2000	MB		X[5]	X[6]	X	X[7]	
Minnesota	95	MB M(ifoff)[8]	X	X	X			
Missouri (A)	97	MO	X	X		X		
Missouri (B)	99	M(ifoff)		X		X		

Montana	99	MB			X	X		
Nebraska	99	M(ltoff)			X		X	
Nevada	99	MB				X	X	X
New Hampshire	94	MB			X			
New Jersey	99	MB			X	X		
New Mexico	2000	MB			X			X[9]
North Carolina (A)	91	MB	X		X	SE only[1]		
North Carolina (B)	97	MB	X	X	X	SE only[1]		
Ohio[10]	90	MB	X	X	X	SE only[1]		
Oklahoma	99	MB			X		X	X
Pennsylvania	98	MB				HMO group	X	
Rhode Island	94	MB			X[11]	X		
South Dakota	98	MB	[12]		X	X		
Tennessee	98	MB	X				X	X
Texas (A)	91	MB			X	SE only[1]		
Texas (B)	97	MB					X	
Utah	2000	MO	X	X			X[13]	
Vermont	97	MB	X	X	X	X		
Virginia	99	MB		X	X	X	X	

[1]State employees only.
Italicized States also enacted statutes to match the 1996 Federal Mental Health Parity Act.
Source: Richard M. Scheffler, Daniel P. Gitterman, Marcia C. Peck, University of California, Berkeley, Center for Mental Health Services Research, *The Political Economy of Mental Health Insurance in the United States*, NIMH grant (MH-18828-11).

TABLE II: DEFINITIONS/VARIATION IN STATE MENTAL HEALTH PARITY STATUTES/REGULATION (X)

[A]**Mental Health Benefit Mandate**: There are three types of mental health benefit mandates:
MB: "mandatory inclusion" mandates—minimum coverage standards—require insurance policies to include certain provisions. A statute that includes a "mandated inclusion" provision typically states that a plan shall provide benefits for diagnosis and mental health treatment under the same terms and conditions as provided for covered benefits for the treatment of other physical illnesses;
MO: "mandated benefit offerings" require sellers to offer certain mental health coverage, with the decision of whether to purchase coverage left to the buyers. A statute that includes a "mandated benefit offering" provision typically states that insurers must make available coverage for the treatment of mental illness, and the coverage must be at least as extensive and provide at least the same degree of coverage as that provided for any other physical illness;
M (if off): "mandated if offered" does not require employer/insurer to offer mental health coverage. However, if employer offers coverage, then the coverage must comply with parity provisions. A statute that includes a "mandated, if offered" provision typically states that in the case of a group health plan that provides mental health benefits, those benefits must be provided on par with benefits for other physical illnesses and insurers shall not establish any rate, term or condition that places a greater financial burden on an insured for treatment of mental illness than for treatment of other physical illnesses.

[B]**Definition of Mental Illness**: "Broad-based mental illness coverage" is defined as encompassing all disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and/or the International Classification of Diseases Manual. Some States allow health plans to define the scope of the mental health benefit. Several States narrow the scope of the statute by requiring coverage for "serious mental illness," most commonly defined as including schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, schizo-affective disorder, and delusional disorder.

[C]**Covers Substance Abuse (X)**: indicates the statute covers drug and alcohol disorders as listed in the American Psychiatric Association's Diagnostic and Statistical Manual or as defined in the statute.

[D] **Set terms and Conditions (X)**: indicates that the statute requires rates, terms, and conditions to be the same for mental illness coverage as for the coverage for all other physical illnesses. Those States that *do not* have an "X" permit a disparity in the terms and conditions required for mental health coverage compared to other physical health conditions. For example, the parity statute may set a cap on the number of inpatient and/or outpatient days required by insurers for mental health coverage, without setting the same cap on coverage for other physical illnesses.

[E]**Individual and Group Plans (X)**: specifies the statute apply to all policies, including individual and group.

[F]**Small employer exemption (X)**: indicates the statute allows small employers an exclusion from compliance. The statutes most commonly define small employers as those with either 25 or fewer employees or those with 50 or fewer employees.

[G]**Cost exemption (X)**: indicates that the statute allows employers that experience a premium increase at or above a specified percentage are excluded from the parity requirements.

[1]Arkansas: An "X" is marked for substance abuse coverage, however, the statute does not require parity for substance abuse because it states that "[h]ealth care insurers providing chemical dependency treatment -- may, but are not required to, comply with -- the terms of this act ..."
[2]Indiana (A) and (B): The existing parity statute that matched the 1996 MHPA and the statute applicable to State employees were amended in 1999. The MHPA match was expanded beyond annual and lifetime limitations to prohibit individual or group plans from permitting treatment limitations or financial requirements for mental illness if similar limitations or requirements are not imposed on coverage for other physical conditions. The federal match and State employee provisions were amended to increase the cost exemption from 1% to 4%.
[3]Louisiana: The statute mandates coverage of serious mental illness and requires a mandated offering for other mental illnesses.
[4]Maine: The statute mandates coverage for group plans and requires a mandated offering for individual policies.
[5] Massachusetts: Existing limitation ($500/ year for outpatient and 30 days for inpatient treatment) for alcoholism or chemical dependency shall not apply when treatment is rendered in conjunction with treatment for mental disorders.
[6] Massachusetts: The statute requires equal terms and conditions for biologically based mental illnesses as defined in the statute, however, does not require parity for other mental disorders.
[7] Massachusetts: The statute exempts businesses with 1 to 50 employees and non-group health plans from compliance until 1 year after effective date of the statute.
[8]Minnesota: The statute mandates coverage for HMOs and a "mandated, if offered" requirement for individual and group plans.
[9] New Mexico: The cost exemption included in the statute requires employers with *at least 2 but not more than 49 employees* to do one of the following if premiums increase more than 1.5% per year: (1) pay the premium increase; (2) reach agreement with the employees to cost-share the amount of the premium above 1.5%; (3) negotiate a reduction in coverage, but not below the coverage existing before the renewal, to reduce the premium increase to no more than 1.5 %; or (4) after demonstrating a premium increase above 1.5 %, receive an exemption. For *employers with at least 50 employees*, if premiums increase more than 2.5% per year, they have the same options as are available for employers with 2 to 49 employees, except the premium increases in the four options must be above 2.5% instead of above 1.5%.
[10]Ohio: The State did not enact a statute. Parity is applicable to State employee mental health coverage through the collective bargaining agreement between the state and the Ohio Civil Service union. The current agreement containing the parity provision is effective 1997-2000.
[11] Rhode Island: The statute includes one limitation that may not result in setting equal terms and conditions: "[i]npatient coverage in cases where continuous hospitalization is medically necessary shall be limited to ninety (90) consecutive days."
[12]South Dakota: The Governor signed HB 1264 in March (1999) to clarify the meaning of the term "biologically based" mental illness. The 1998 statute required parity for biologically based mental illness, defined as "any mental illness which current medical research affirms is caused by a neurobiological disorder of the brain and which substantially impairs perception, cognitive function, judgment, and emotional stability and which limits the life activities of the person with the illness. The term includes schizophrenia; schizo-affective disorder; bipolar affective disorder; major depression; obsessive-compulsive disorder, and other anxiety disorders which cause significant impairment of function; and other disorders proven to be biologically-based mental illnesses." The 1999 amendment to the statute narrowed the definition of biologically based mental illness to "schizophrenia and other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder."
[13] The statute has a unique approach to small-employer exemptions: It requires insurers to offer an additional option for small employers that insurers need not offer to large employers. Specifically, the statute requires insurers to offer small employers (2-50 employees) "50/50 mental health coverage" — meaning coverage in a health insurance policy or health maintenance organization contract that pays at least 50% of covered services for the diagnosis and treatment of mental health conditions. The "50/50" coverage may include a restriction on episodic limits, inpatient and outpatient service limits, or maximum out-of-pocket limits.

NOTE: THE REPORT ENDS HERE. THE REMAINING TEXT IS SUPERFLUOUS. IT CANNOT BE ERASED, SO PLEASE TOSS THIS AND SUBSEQUENT PAGES.

APPENDIX D: Comparing Parity Cost Estimates Using Actuarial Models

The new NAMHC estimate of a 1.4 percent cost increase in total health insurance premiums due to parity is lower than previously reported estimates based on Hay Group actuarial models (all were of similar magnitude). Previous estimates include the 1996 Congressional Budget Office (CBO)/Congressional Research Service (CRS) 4.0 percent increase, the 1998 Substance Abuse and Mental Health Services Administration (SAMHSA) estimate of 3.6 percent, and estimates from the previous NAMHC report, as shown in the Table below. Because each of the Hay Group model-based estimates uses the same basic methodology it is important to understand what drives the latest estimate.

Table. Cost of Full Parity Estimates Based on Hay Group Actuarial Models

		Increase in Total Premium	
Estimate	Model Version*	FFS Plans	All Plans
CBO/CRS (1996)	HCBVC 6.5	5.3%	4.0%
NAMHC (1998)	MHBVC1.7	4% to 5%	<1 to 4%
SAMHSA (1998)	MHBVC1.7	5.0%	3.6%
NAMHC (2000)	MHBVC2.0	1.4%	1.4%

* Principal model for mental health/substance abuse cost estimates (separate model used to calculate non-mental health costs for HMOS in all but CBO/CRS study).

The different Hay Group models (HCBVC 6.5, MHBVC1.7, MHBVC2.0) work essentially the same way. The Hay Group uses actuarial methods to develop an expenditure grid, which represents the extent of medical, mental health, and substance abuse service use by plan enrollees if they paid nothing out of pocket (i.e., if the plan paid 100 percent). Combinations of induction factors (which measure how responsive enrollees are in reducing their health care use when faced with higher out-of-pocket costs) and management factors (which measure how costs are reduced with utilization review and other managed care practices) are then used to estimate how much care enrollees would use when faced with a particular set of copayments. Administrative loading factors are used to multiply these costs to determine the estimated premium for a particular health care benefit package.

The cost of a change in the health care benefit package, such as mental health parity, is simulated by first estimating the cost with existing benefits in the Hay model and then estimating the cost with the new benefits. All other assumptions are held constant

(except, of course, for benefits). Because both baseline costs and benefits differ in fee-for-service (FFS), preferred-provider organization (PPO), point-of-service (POS), health maintenance organization (HMO), and managed behavioral carve-out plans, the Hay models were used to compute separate estimates of the cost of parity for these different types of health plans. The 1998 SAMHSA and the 2000 NAMHC estimates then combine these separate estimates (using assumptions about the distribution of enrollees across types of plans) to produce a single estimate of the total cost impact of mental health parity. The previous NAMHC (1998) report did not present a single cost estimate, but rather a range of estimates based on the different plan types. The CBO/CRS estimated a typical FFS plan and then made an ad hoc adjustment downwards to reflect managed care.

The major difference between the current NAMHC estimate of 1.4 percent and previous estimates appears to be driven by the evolution of the Hay Group model as it is updated to reflect changes in the underlying distributions of mental health and health care expenditures. The most recent version of the Hay Group model (MHBVC2.0) assumes an average mental health and substance abuse cost per enrollee (with no out-of-pocket costs) that is fully *one-half* that of the Hay Group model used for the 1998 SAMHSA and the previous NAMHC report estimates, and *one-third* that of the model used for the 1996 CBO/CRS estimate (NAMHC calculations from Hay Group models). The most recent Hay Model incorporates new data from the FFS/PPO plans of the Federal Employees Health Benefit Program (FEHBP), several large managed behavioral health care companies, and the FFS plan of a large State employees health plan (described in Section III of this report). The experience of the FEHBP program, along with other evidence, suggests that mental health and substance abuse costs have declined substantially during the 1990s, mainly due to sharply reduced inpatient utilization even in FFS/PPO plans. Because mental health costs have declined, especially as a proportion of total health care costs, the estimated impact of a mental health parity benefit in terms of the increase in total premiums has correspondingly declined.

There are other much smaller differences in the assumptions used between current NAMHC estimate and previous estimates. The assumptions are discussed in more detail below, but in general these explain little of the differences between the estimates. (A useful companion to this discussion of the estimates is the report by Sing and Hill (1998) detailing the assumptions used to generate the 1998 SAMHSA estimates.) This is illustrated by the fact that when the NAMHC (2000) assumptions are applied to the previous version of the Hay Model (MHBVC1.7) used to produce the 1998 SAMHSA estimate, the estimated impact of parity is 3.7 percent instead of 1.4 percent (*preliminary* NAMHC calculations from the MHBVC1.7 model). That is, when the same assumptions are applied to mental health treatment patterns prevailing several years ago, the estimated cost of parity is 3.7 percent, but taking into account recent trends in mental health costs reduces the estimated cost of parity to a current level of 1.4 percent.

Other Differences in Basic Assumptions

Family vs. single premiums: The current NAMHC estimate is for singles only, while the other estimates represent the percent increase in total family premiums. Preliminary calculations using the new Hay model suggest that increase in total family premiums would be approximately 1.6 percent, a slight increase from the 1.4 percent for the single premiums.

Distribution of Health Plans: The 1998 SAMHSA and the current NAMHC estimates assume different distributions of types of health plans, but this difference has no effect on either estimate. That is, applying the 1998 SAMHSA distributions to the current NAMHC estimate produces the same estimate, and vice versa. (The 1998 SAMHSA

estimate assumes a distribution in which 20 percent of plans are FFS, 30 percent PPO, 20 percent POS, and 30 percent HMO, compared to a distribution of 14 percent, 40 percent, 20 percent, and 26 percent respectively in the 2000 NAMHC estimate.) The CBO/CRS estimate contains an unknown adjustment for managed care plans from their base FFS estimate.

Carve-outs: The current 1.4 percent NAMHC estimate includes an adjustment that assumes that 20 percent of FFS, PPO and POS plans have carved out their mental health and substance abuse benefits. This 20 percent factor is the same for both the current and parity benefit cost estimates. Several surveys estimate that in at least 20 percent (KPMG Peat Marwick, Hay Group) of these types of plans among medium and large employers, the employer separately contracts (carves-out) with a managed behavioral health firm. This 20 percent is a conservative estimate of carve-out management since FFS, PPO, and POS health plans may themselves subcontract (carve-out) behavioral benefits, but there are no good estimates of the extent of these indirect carve-outs. The 20 percent carve-out adjustment has a negligible impact on the current NAMHC estimate—without it the estimate is 1.5 percent—because the difference between cost increases in carve-out plans and non-HMO plans have decreased considerably. However, applying the 20 percent carve-out adjustment to the 1998 SAMHSA estimate would considerably reduce it from 3.6 percent to around 3.0 percent.

Benefits: All of the estimates use the same basic assumptions about existing mental health and substance abuse with one exception. The CBO/CRS estimates assumed that a $50,000 lifetime maximum applied to mental health benefits, while all the other estimates occurred after the federal parity legislation that removed this limit. There were slight differences across the different estimates in the assumed medical/surgical benefits, but these differences likely had little impact on any of the estimates.

Management Factors: The Hay Group models all incorporate a management factor to account for the effect of use of utilization review and other managed care techniques in reducing costs. The factors were, for the most part, the same across all of the estimates and the same factor was used to estimate both the cost under current benefits and under a parity benefit. The 1998 SAMHSA estimate includes a management factor for FFS, PPO, and POS plans that implies a reduction of 25 percent in mental health and substance abuse costs compared to unmanaged costs, but no reduction for HMO costs because the tighter management in HMOs are already reflected in the HMO expense grids. The current NAMHC estimate uses the same 25 percent management factor adjustment for FFS, PPO, POS, HMO and carve-out plans to estimate costs under current and under parity benefits. Preliminary NAMHC calculations suggest that if the 25 percent adjustment for HMOs and PPO is eliminated, the current NAMHC estimate of 1.4 percent overall increase in premium costs due to parity would change slightly to 1.5 percent.

Induction (Demand Response): All the estimates based on the Hay Group model use the same induction factors, which are derived from the RAND Health Insurance Experiment, with one small exception. The 1998 SAMHSA estimates used slightly lower induction factors for HMO plans. However, this makes little difference in the overall estimates.

Administrative Factors: The Hay Group model multiplies the base claims costs in their models by an administrative loading factor, which represent a fixed percentage of the total claims costs for administrative costs and profit (where applicable), to obtain the total premium cost. The current NAMHC estimate uses the same administrative factor of 1.11 for all types of health care plans (carve-outs, HMO, FFS, PPO, POS). The 1998 SAMHSA estimate used the same administrative factor of 1.11 for FFS, PPO, and POS plans but higher loading factors of 1.15 for medical/surgical expenses and 1.2 for behavioral coverage. However, because these administrative load factors multiply both the numerators and denominators, the effect of differing administrative load factors tends to be canceled out when examining changes in premium costs.

References:

Hay Group (1999): *Employer Mental Health Coverage Features and Compliance with the Mental Health Parity Act. Hay Report for NIMH, June 1999.* (unpublished).

KPMG Peat Marwick, *Health Benefits in 1997*, June 1997.

Sing M. and Hill S. (1998): *Predicted Premium Increases Due to Full and Partial Parity for Mental Health and Substance Abuse Insurance Benefits.* Report Submitted to the Substance Abuse and Mental Health Services Administration. Washington, DC: Mathematica Policy Research, Inc.

Senator WELLSTONE. Quickly, first, for Dr. Hyman—and you know how much I appreciate all the work that you are doing—do you foresee a time when mental illness can be explained—you were talking about the Parkinson's analogy—through biology and neurology?

Dr. HYMAN. Absolutely. And here, I just want to make the point that the brain is the most complex object in the history of human inquiry. If we have been slow, it is not because we have not been trying, but because of the extraordinary complexity of an organ that after all underlies our mental lives, our behavior, it has to be complicated.

We increasingly have the tools—the results of the Genome Project; the tools of neuroimaging—to understand the brain. I also want to point out that the brain is the great integrator. I pointed out the genetic nature of risk of many mental illnesses, but it is also important to recognize that I am not talking here about some kind of biological determinism or separation of biological from other experience, because the brain also records in permanent changes in its physical structure those things that happen to us as human beings.

In the end, we will have explanations for these illnesses.

Senator WELLSTONE. I may come back to you in a moment, Dr. Hyman, but I do not want to run out of time before getting to Ms. Allen.

In your report, employers seem to acknowledge quite freely that they are adding additional restrictions to people who are struggling with mental illness regardless of the nature or the severity of the illness. Did you get any information that might explain why these employers feel this practice is acceptable? How are they talking about this?

Ms. ALLEN. Well, the indication is that, as mentioned earlier, they are concerned about the bottom line cost. They are concerned that they be able to somehow constrain the cost, perhaps in the absence of more widespread evidence and information. But again, we think the evidence from other States is very instructive—that those States which have imposed full parity in every respect, including copayments, and particularly those that have well-managed care, the increased costs are simply not there.

So we think that the evidence here could perhaps help change their behavior.

Senator WELLSTONE. I know that my State of Minnesota is one example. And again, Dr. Hyman, that is why I think your 1.4 percent figure is so important.

Dr. HYMAN. It is also important—and I think it is important that we have Delta Airlines testifying here—that employers recognize the cost offsets in terms of other medical utilization and disability, and that especially in a full-employment economy, where we should be invested in our workers, it makes absolutely no sense to skimp on the treatment of illnesses like major depression.

Senator WELLSTONE. There is one other thing that we should probably clarify just for this hearing. Could you clarify further what "full parity" means in this report? I mean, is there a consist-

ent definition in different States, or are we talking about different things?

Ms. ALLEN. We found that 16 States do have full parity, and that is in terms of what is covered as well as the cost-sharing and the price to the employee and to the employer; so in every respect. It includes substance abuse, severely mentally ill, and all cost-sharing provisions.

Senator WELLSTONE. And in other States?

Ms. ALLEN. There is some variance. In all, I think we identified 29 States that meet or exceed the Federal parity law in some respect. They may have adopted, perhaps, coverage for some types of services; perhaps there is parity in visits or day limits but not cost-sharing. So it would vary somewhat, but beyond what the Federal parity law would require.

Senator WELLSTONE. And finally, Dr. Hyman, I really appreciate your emphasis on what can be explained by the biology and neurology. Are you then also saying that medication is the only method of treatment?

Dr. HYMAN. Absolutely not.

Senator WELLSTONE. I ask that because that is a very——

Dr. HYMAN. Yes—I saw the twinkle in your eye, Senator, when you asked that question. But you know—and we have talked about this before—if somebody had a heart attack, and they showed up at the doctor's office, and someone just wrote them a prescription and sent them on their way, no one would consider that adequate care. People would get dietary counseling, exercise and rehabilitation programs, stress reduction, and that is considered appropriate care.

There was just a paper in The New England Journal of Medicine that came out yesterday which showed yet again that for people with chronic depression, for example, the combination of 16 sessions of a cognitively-based psychotherapy with medication had marked advantages for that population compared with other treatments. Both medications and psychosocial treatments work, and indeed, psychosocial treatments work because they work on the brain.

Senator WELLSTONE. Thank you. I hope all managed care companies heard that.

The CHAIRMAN. Just to announce that we are going to have a change here. There is a Democratic objection to the committee's meeting under the 2-hour rule, so the hearing must conclude, and we will begin a "committee seminar," and I will ask consent that the seminar proceedings be included in the record.

Is there any objection to including the seminar proceedings in the record?

Senator KENNEDY. I will not object, Mr. Chairman. I just want to apologize to our witnesses. I had looked forward to questioning. I have no objection.

The Democratic objection is obviously not focused on this particular hearing; it involves a much broader game in terms of the agenda on the Senate floor. We are getting involved in gun issues, minimum wage, and other kinds of issues as we come closer to the national election. So it is not just an incredible inconvenience for

those of us who would like to continue this hearing, but it is a larger issue. So we extend our apologies to our guests and witnesses.

But I agree with the chair that we should have all the statements in the record.

The CHAIRMAN. The committee is adjourned.

[Whereupon at 11 a.m., the committee was adjourned.]

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
SEMINAR ON MENTAL HEALTH PARITY

THURSDAY, MAY 18, 2000

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The seminar met, pursuant to notice, at 11:03 a.m., in room SD–430, Dirksen Senate Office Building, Senator Jeffords (chairman of the committee) presiding.

Present: Senators Jeffords, Collins, Kennedy, Dodd, Wellstone, Murray, and Reed.

The CHAIRMAN. I think we can continue; I am the only one who suffers, and not too directly, since I have to pay for the recorder personally; but outside of that there is no detriment, so we will proceed.

Senator KENNEDY. I am glad to join you.

Senator DODD. Wait—some of us are in a better position. [Laughter.]

Senator WELLSTONE. Yes, as long as it is pro-rated.

Senator KENNEDY. I was going to say on the proportion of distribution of funds between the majority and the minority—that is another issue you as a psychiatrist, can begin to understand.

The CHAIRMAN. Yes, we would like your analysis. [Laughter.]

Dr. HYMAN. But not on the record, I imagine.

The CHAIRMAN. Right.

Let us proceed. Senator Kennedy, it is your turn.

Senator KENNEDY. Thank you, Mr. Chairman.

Dr. Hyman, I personally believe that we are in the "life sciences century" with all of these incredible possibilities and breakthroughs in areas which you have mentioned. I think there is a general acceptance of that in many of these other areas of disease. Do you see this as well in terms of the whole issue of mental health? And perhaps you could illustrate in ways that will help us be able to make the case about the importance of investing resources in this area.

Dr. HYMAN. Yes. I will try to be very brief here, but there is no doubt. Actually, although I am a psychiatrist, I am a molecular biologist, and I study in my own laboratory the regulation of turning genes on and off in the brain because it is relevant to mental illness.

The brain is an organ like any other. It is built by an interaction between genes and our environment, like any other, only it is so

much more complicated than any other organ, as befits something that underlies the wonder of humanity—humanity that can build cathedrals as well as suffer from mental illness.

We are steadily gaining an understanding of how the brain is built, how it operates, and what goes wrong in mental illness. Let me just put up one picture to show you something in schizophrenia.

Actually, this is not a new finding but is, I think, quite illustrative. I hope you can see it from where you sit. Here, we have two identical twins, one of whom has schizophrenia and one who does not. And maybe General Wyblinger from my staff can point out the ventricular enlargement. If you compare this twin to that twin, the twin on the right, the one who has schizophrenia, has much larger fluid spaces in his brain than the unaffected twin on the left, denoting loss of tissue that we believe occurs during brain development in schizophrenia.

This, although a true finding, is still rather crude; it does not yet explain why people have hallucinations and delusions. But increasingly, we are finding brain abnormalities that will explain the symptoms of mental illness, and I look forward to the day—although, because of the complexity, it will take us some time—when we will have equally satisfying explanations for hallucinations and delusions or the loss of normal human interaction in autism, or the mood swings of manic depressive illness, as we have for why somebody has a heart attack.

Senator KENNEDY. That is enormously encouraging.

In your statement, you mentioned one large State that has done this. Could you tell us what State that is?

Dr. HYMAN. The State for some reason does not want to be identified.

Senator KENNEDY. With all that good news, you would think the State would want to be named.

Dr. HYMAN. But NIMH agreed, in getting their Blue Cross/Blue Shield data—it really has to do with Blue Cross/Blue Shield not wanting to have any trade secrets or whatever inferred from the data.

Senator KENNEDY. Finally, I would like to ask Ms. Allen a question. The GAO survey had a response rate of 52 percent. Do you have any information about the 48 percent of the employers who did not respond?

Ms. ALLEN. We looked at the nonrespondents in terms of the size of employer, the geographic location, their type of business, and we found no discernible pattern, no discrepancies, no difference, so we believe it does not unduly jeopardize the findings.

Senator KENNEDY. And do you have any suggestions about how we might get the other 14 percent to comply?

Ms. ALLEN. It is a very important role for the Department of Labor and the Health Care Finance Administration and their Federal oversight role as part of their obligation to the consumers to indeed determine the rate of compliance and to bring this into compliance. So it is a very important Federal responsibility.

Senator KENNEDY. I will not take the time of the committee now, but I might ask you to elaborate on that because that is going to be very important, and your testimony on that will be very, very helpful to us.

This has been a very helpful panel, Mr. Chairman, and I thank you both.

The CHAIRMAN. Senator Dodd.

Senator DODD. Thank you, Mr. Chairman, and I apologize for missing Senator Wellstone's statement. I would ask unanimous consent that some general remarks be included in the record.

The CHAIRMAN. Without objection.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman: Thank you for convening this hearing on the critical issue of parity of insurance coverage for mental health services.

I would also like to thank Senators Domenici and Wellstone for their tireless advocacy on mental health issues. No members of the Senate have done more for individuals with mental illnesses and their families than our colleagues who are testifying before us today.

In any given year, 40-50 million adults—nearly 25 percent of the U.S. adult population—suffer from a mental health or substance abuse problem. And each year, approximately 5.5 million Americans are disabled by a severe mental illness—such as schizophrenia, autism, or bipolar disorder.

In the average crowd, if you ask people to raise their hand if they've been touched by mental illness—either their own or the illness of a loved one—almost every hand will go up.

Yet, despite the prevalence of these conditions, mental illness is an issue that remains shrouded in secrecy and stigma.

In fact, a report by the Surgeon General, which was issued last December, noted that almost two-thirds of Americans with diagnosable mental disorders don't seek treatment because they fear being stigmatized.

Clearly, we must do more to raise awareness about mental illness. But while we fight the battle on that front, we must also address the concerns of individuals who risk stigmatization and seek mental health treatment only to find that their access to help is blocked by discriminatory restrictions in insurance coverage.

Despite the fact that a range of effective treatments exist for almost all mental disorders, those suffering from mental illness often face hurdles higher than those faced by individuals seeking physical health services—higher copayments, lower numbers of covered hospital days, or restrictions on doctors' visits.

Not only do such practices set us back in our efforts to de-stigmatize mental illness, but they also drive up the societal costs of mental disorders. When mental illness goes untreated, physical health deteriorates, jobs are lost, and families are destroyed. The National Institute of Mental Health estimates that the annual cost of untreated mental illnesses exceeds $300 billion.

I applaud Senators Domenici and Wellstone for their efforts to address this very troubling situation and I share their concern that mental health care not take a backseat to other health conditions. I am pleased to have joined them as cosponsors of both the 1996 Mental Health Parity Act and Mental Health Equitable Treatment Act of 1999.

It is my hope that within the next decade, we will begin to see a greater public understanding of what mental illness is not—a

character flaw or willful malingering—and what it is—a cluster of diseases that in many cases are treatable, just like physical illnesses.

Mr. Chairman, I thank you again for holding this hearing. I look forward to working with you and other members of the Committee to address this critical public health issue.

Senator DODD. I will just say very briefly, Mr. Chairman, that I think this is an important hearing, and I am particularly grateful to Senator Domenici and Senator Wellstone of our committee for their leadership on this issue.

I would like to address a couple of issues if I could. One has to do with the recent report in The New England Journal of Medicine about the practice of prescribing powerful behavioral drugs to young children.

Dr. HYMAN. Yes, Senator.

Senator DODD. In fact, we drafted and sent a letter to NIH as well as to the FDA which you may be familiar with to get some comments from you on this.

Dr. HYMAN. Yes.

Senator DODD. This is very disturbing to me that drugs that we know so little about are being so widely used, with the drugs becoming almost a "babysitter" in some cases—or at least, that was the allegation or suggestion.

But a corollary to that which I have just begun to learn about, is that in upper-income communities, you are seeing an overuse of these drugs, and in lower-income communities, you are seeing under use of them, which can also be dangerous.

Dr. HYMAN. Yes.

Senator DODD. Please excuse my layman's language here to describe this, but I want you to flesh this out a bit for me, and I would like you to talk about this a bit. What should we be worried about? This is of great concern to an awful lot of people.

Dr. HYMAN. Yes. Senator, I am aware of your longstanding concern about children, and in fact, you are right—a paper actually come out in the Journal of the American Medical Association. And what was particularly concerning was that it looked at a substantial increase in the use of psychotropic drugs in preschoolers, an age group for whom we have no information about safety or efficacy of psychotropic drugs. One of the drugs in wide use is something called Quinidine—not widely; it was less than one percent of the children, but still not a trivial number—also has substantial side effects, so there is an enormous concern.

But let me speak to the larger issue. You are absolutely right—there is a major disparity between inner city, especially minority communities, and middle-class and upper middle-class majority communities in the diagnosis of attention deficit disorder and the prescription of psychotropic drugs to children, specifically Ritalin, and also Prozac-like antidepressants for children with depression. And to be brief about it, this is basically following patterns not dictated by appropriate diagnosis or medical necessity. What we see in inner cities is that there are actually active campaigns which often construe psychotropic drug use as oppressive chemical restraints or handcuffs on minority youth, and there have been some active campaigns. I was just in Chicago visiting with the minority

community, and Dr. Carl Bell, who is a psychiatrist there, showed me a campaign that described Ritalin as "a genocidal plot." The issue there is for children who really do have attention deficit disorder—between 3 and 5 percent of children—failure to treat means that they cannot learn in school, and there is very good outcomes data that they are more likely to engage in substance abuse and have bad outcomes.

One anecdote which is very instructive is that the Justice Department, which has very little money for research, actually collaborates with the National Institute of Mental Health to study attention deficit disorder, because these children become so overrepresented among incarcerated youth. And the Surgeon General is also very interested in this disparity. So there, there is underdiagnosis and underuse.

In contrast, what we see in many middle-class communities is often school-led pressure toward the use of these drugs. What happens, basically, is that a classroom—and here, forgive me; because of the brief time, I may end up caricaturing, and I do not mean to——

Senator DODD. This is very important, so please take a little time. Go ahead.

Dr. Hyman [continuing.] I do not want to blame teachers or be seen as bashing anybody, but what they will recognize is that a classroom will become easier to manage because actually, Ritalin will help anybody concentrate better and give them greater ability to stay in their seat.

What we see is that a teacher will ask a parent, Could you have your child evaluated for the use of Ritalin? Then, most often, the scenario is that the parent will go to a family physician or pediatrician who often has no specific training in either behavioral pediatrics or psychiatry or these psychological issues. The evaluations will be too short—and here, managed care and the pressures on the time of pediatricians and primary care practitioners is an enormous factor—there may be a 7- or 10-minute evaluation.

Now, to make the diagnosis of attention deficit disorder, one should observe the child, talk to the parent and talk to the teacher. A child has to have problems in more than one setting before we know that he or she has this diagnosis.

Instead, often, after a short evaluation, a script will be written. In the American Journal of Public Health last fall, a paper came out suggesting that in suburban Virginia counties, Caucasian male youth were being treated with Ritalin as many as 20 percent in a class, which is really quite a number.

In addition, the follow-ups are inadequate. An important question to ask whenever you use a psychotropic drug in a child is do the benefits is do the benefits outweigh the costs in terms of any side effects or risks. In this case, one would want to know whether academic performance has improved, whether the child is staying on growth curves.

Let me sum up by saying the one thing that I have not said but which is very important—for well-diagnosed attention deficit hyperactivity disorder, there is substantial and convincing evidence that Ritalin is safe and effective. The longest study is 14 months, one school year plus a summer. It is very hard, ethically, to keep

a child in an experiment for longer than that. But Ritalin is safe and effective.

But what we have, despite that medical data is for social and political reasons, underdiagnosis and undertreatment, putting minority youth in many cities at a disadvantage, and then overdiagnosis and overtreatment in many suburban communities, where in some sense, we have the analogy to an anabolic steroid for academic performance at some risk. And as you know, both are equally concerning.

Senator DODD. What would you recommend? Obviously, we do not have to legislate in every case, but by inquiring and urging in the letter we sent to NIH as well as to the FDA. Are there steps that could be taken from a regulatory standpoint that could assist in this regard?

Dr. HYMAN. At this point, the one area of regulation that was considered was whether the FDA might ask companies to look at safety and efficacy of drugs, really to establish safety above all, as well as efficacy, in preschoolers where these drugs are being increasingly used. The consensus is that there is not enough data for the FDA to actually approach industry at this point in the sense that for depression, it is very hard to make a diagnosis under the age of 6.

So we have taken this up at NIMH. We have just funded a large-scale safety and efficacy study of Ritalin in preschoolers—now, these will be kids who are very impaired—and we are trying to encourage the development of a study of Prozac-like antidepressants in school-age kids. We do have a large-scale study in adolescents. Once that kind of data is in, FDA will be in a better position to consider its options.

The other thing—and I know your staff has been briefed on this—is that the Surgeon General is going to have a conference, hopefully in August or September of this year, bringing together, very importantly, not just psychiatrist but pediatricians, family physicians, school nurses, and teachers, to see where we all are on this, to see if we can get on the same page; and I think the outcome of that conference will be very interesting in terms of what solutions there might be. In addition, NIMH and FDA are going to have a conference to try to define what information we need to ensure the safety and health of our children.

The CHAIRMAN. I would like to pursue this. In this area, there is another question of parity that I would like to understand, if anyone is able to provide an explanation.

In the Cedar Rapids case on special education, the courts ruled that the school system is responsible for providing the necessary medical treatment for youngsters. I do not suppose there is any history to look at, but I wonder what thinking is going on, who is responsible, and whether or not there is any look at parity with respect to young people and special education.

This is a critical question, because we are going to have terrible debates on the House floor—the Senate floor, rather—well, probably both—on the question of disruptive kids in the classroom and who is responsible for treating them and what their rights are.

I wonder if you could comment on that, Dr. Hyman.

Dr. HYMAN. Let me comment on two fronts. The first has to do with the fact that we really do not fully understand the economics. However, when a school district is told that they are going to have to pay for certain disorders, it creates an extraordinary disincentive for them to help discover early on those disorders in children. We have been talking with the Department of Education about this tradeoff between the economic burden to school systems, which can be real, and also the mental health needs of children and the critical need for early intervention.

The second thing is the opposite—as we change standards for disability, savvy parents will begin to push for a particular diagnosis that is covered in their children. We suspect, for example, that there may be a true increase in the incidence of autism in the United States, but we cannot tell, because the rates of diagnosis are masked by the changing incentives created by what that diagnosis means in terms of coverage for educational benefits for children as opposed to medical benefits.

So this is an area that does require additional investigation.

But you raised another very important issue which has to do with balancing the rights of our children against their medical needs and also the needs for the safety of the community. Here, I have a comment which I think is very important.

There is a great difference between looking at kids to make an early diagnosis of a disruptive disorder or a mood disorder with a view toward treating them before trouble occurs and the tendency, which I have been very troubled by after Littleton, to profile children rather late and say who is at risk of being a violent perpetrator.

I think this Nation is skeptical of profiling individuals, whether it is by State police on highways or of our children, and the reason for that is that the number of children who will actually go on to be violent fortunately is quite small; but a profiling approach is going to give you a larger umber of children, and we have to worry about whether kids who are identified as potentially violent by some simple pencil and paper test are not going to be stigmatized, extruded, or in some way harmed so that we may even create a self-fulfilling prophecy.

And I think this is not just splitting hairs. I think it is a very different approach when you are looking from an early intervention and therapeutic point of view at identifying kids with disruptive disorders and depression as opposed to saying we want to weed out the potential bad actors with a profiling approach. I think that that is something we all have to think about very, very carefully.

The CHAIRMAN. Ms. Allen, do you have any awareness of any studies that have been done to look into these areas?

Ms. ALLEN. No studies per se, but I would comment that this is an issue—the Olmstead case which you refer to—that is of particular concern also to those administering the Medicaid program. Particularly for students or children who have very intensive and expensive needs, it is entirely possible that they would qualify for the Medicaid program through a disability, and these costs would be shared by the Federal and the State Governments.

There is some concern about what that will mean in the future. As yet, I am not certain that there are that many cases and inci-

dents that have come forward; but it certainly is on the horizon of potential increased cost.

The CHAIRMAN. Thank you. It is disturbing, and this is a matter that we will have to deal with again when we get to special education questions.

Senator Wellstone.

Senator WELLSTONE. Chris had a question. Go ahead.

Senator DODD. No. Go ahead, Paul.

Senator WELLSTONE. The only comment I would make, Steve, is that I had asked you earlier the question about whether the focus should be just on pharmacological treatment alone, and think part of what we are talking about with kids is also what gets covered and what does not get covered. From the point of view of a lot of these plans, this is the cheapest coverage.

So when it comes to kids who do not necessarily need this but could use a lot of other help, that is not available.

Dr. HYMAN. Right.

Senator WELLSTONE. So in some ways, it just follows the money stream of what is covered.

Dr. HYMAN. There is a little jingle: "Pills do not teach skills." And often, kids will need both if they are very ill; they need the medication so they can utilize treatments in school, but they are going to need more.

Senator WELLSTONE. And the only other thing I was going to mention about profiling is that I think I have been in a school every 2 weeks in Minnesota, and I have heard a lot of discussion—and this seems almost off the topic, but since you mentioned profiling. It seems like at every assembly or in every class, there are students who say that because they dress a certain way or because they are different, they are really getting very angry about the way in which people are putting them into categories and viewing them. I think that is what you are saying.

Dr. HYMAN. Yes; it is not therapeutic.

Senator WELLSTONE. Yes; not therapeutic.

The CHAIRMAN. We do have another panel, so I think we should move on.

Senator DODD. If I could just ask a couple of quick questions, Mr. Chairman.

Following up on this, we have asked the Food and Drug Administration to move up their studies on behavioral drugs used in children. Senator DeWine and I, as you may recall, passed legislation that encourages the testing of pharmaceutical products for children specifically rather than relying on grandmother's good, sound advice of carving up aspirin and so forth—and they are moving on that. We have asked them to move ahead particularly in the area of products like Ritalin, Prozac, and related substances.

Do you think that that is important to do?

Dr. HYMAN. It is critical.

Senator DODD. Providing it is safe and effective.

Dr. HYMAN. Yes. I was going to say there is evidence that 5 percent of America's children are exposed to an antidepressant drug sometime in their lives. For the modern antidepressants there are, I think, a total of 40 children—school-age kids, not adolescents; we know more about adolescents—who have been included in appro-

priately designed trials of safety and efficacy. In short, we know nothing.

Senator DODD. Finally, I want to pick up on something that Senator Wellstone raised. I try—and I have not done it as religiously this year—but I try to speak at a public high school in my State every week. I have visited virtually every one of them over the last 15 years, and I try to get back to some of my inner-city schools more frequently just because of the economic problems.

I must tell you that I have run into some interesting conversations. I asked the principal of Danbury High School in Connecticut, which is in the western part of my State, right after the tragedy at Columbine, could this happen in our school. I guess every parent probably asked the same question as well.

He said that, obviously, it could, but it is less likely here because we have such a diverse student body. In fact, he said, I have parents from small suburban or rural communities nearby who are willing to pay whatever the amount for their children to go to the public school in Danbury rather than stay in the public school in their own smaller town, because they see their children as being somewhat different and not fitting in, whereas in the other school, where there is a more diverse population, it acts as a shock absorber—there are places where they can feel comfortable. I am not articulating this very well, and that is not to say that the suburban and rural schools are not doing a good job; it is just that you are much more likely to get a homogenous population, racially and economically and so forth, whereas in a larger setting you are more likely to get a diverse population.

The point I am trying to make here is to what extent are we looking at environments where children are being raised in terms of minimizing the kind of isolation which can provoke some of the tragedies that we have seen.

Dr. HYMAN. Senator, again, with these illnesses, the bar is set partly by your genes and early development, but the environment, especially for disorders of mood, for example, and for many disruptive disorders, is also impacted by your immediate environment, so we do have to pay attention to that.

All I can say to bring this full circle to the parity debate is that what we are talking about if we are going to have healthy schools and safe schools is a need to ensure that in some way, all of our children can have appropriate, therapeutically-driven interventions when they are in need and that we not end up in this terrible situation of doing things too late when some things might be helpful and some things might be harmful.

Senator DODD. I have taken a lot of your time. I apologize, Mr. Chairman.

The CHAIRMAN. That is quite all right.

Senator WELLSTONE. It is okay—it is a seminar.

Senator DODD. Yes—it is a seminar; it is not hearing.

The CHAIRMAN. That is right. It is an excellent seminar, and I appreciate your participation.

Thank you.

It is our pleasure now to welcome our third panel of witnesses.

First, I would like to introduce Dr. Ken Libertoff, executive director of the Vermont Association of Mental Health in Montpelier. Dr.

Libertoff has led an effort to pass legislation to help regulate the State's managed behavioral health care industry. He also worked to achieve passage of the Nation's most comprehensive mental health and substance abuse parity bill which, when passed in 1998, set a new standard in the country for parity. Dr. Libertoff holds a doctorate in clinical psychology and public practice from Harvard University.

Dr. Libertoff, it is a pleasure to have you, and we welcome you here.

I am also pleased to introduce the second member of today's panel, Dr. Kenneth Duckworth, who is deputy commissioner of the Massachusetts Department of Mental Health in Boston. Dr. Duckworth is also assistant professor of psychiatry at Harvard Medical School. Since 1997, he has been co-chair of the Anti-Stigma Campaign for the Massachusetts Alliance for the Mentally Ill. Dr. Duckworth is a graduate of the University of Michigan and the Temple University School of Medicine. He has diplomas in adult, child and adolescent, and forensic psychiatry. Among his many awards and honors, he has been presented the Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill, and the Outstanding Psychiatrist Award for Clinical Psychiatry from the Massachusetts Psychiatric Society.

I would like to add a personal note of recognition, that today is Dr. Duckworth's birthday, and we all wish you happy birthday.

Dr. DUCKWORTH. Thank you.

The CHAIRMAN. Also appearing on the panel this morning is Ms. Tara Wooldridge, manager of the Employee Assistance Program at Delta Air Lines in Atlanta, GA. Delta was mentioned earlier, and we are pleased to have you here. As such, Ms. Wooldridge developed an internal EAP to deliver comprehensive services to the company's 75,000 employees. Based in the workplace, EAP programs help identify and resolve behavioral, health, and productivity problems hampering employees' welfare or performance on the job. A licensed clinical social worker, Ms. Wooldridge spent 10 years in the field of human resources, introducing principles of social work practice to the corporate environment. She has also advocated employer responsibility to address mental health care issues in the workplace. Ms. Wooldridge holds a master's in social work from Clark Atlanta University and a national credential from the Academy of Certified Social Workers.

It is a pleasure to have you with us today, Ms. Wooldridge.

Finally, I am pleased to introduce Dean Rosen, senior vice president of policy and general counsel for the Health Insurance Association of America, HIAA. Mr. Rosen directs HIAA's analysis of legislation and regulations for their possible consequences for the insurance industry and health care system. He oversees HIAA's public policy agenda and also represents HIAA on all legal matters. Previously, Mr. Rosen was majority counsel for the House Ways and Means Health Subcommittee, and he served as health policy coordinator and majority counsel to the Senate Committee on Labor and Human Resources, advising the chair, Senator Nancy Kassebaum, on such matters as the Health Insurance Portability and Accountability Act. Mr. Rosen is a graduate of Syracuse Uni-

versity College of Law and earned an M.S. from S.I. Newhouse School of Public Communication.

Welcome, and we appreciate your being here.

We will start with Dr. Libertoff. Please proceed.

STATEMENTS OF KEN LIBERTOFF, DIRECTOR, VERMONT ASSOCIATION FOR MENTAL HEALTH, MONTPELIER, VT; DR. KENNETH DUCKWORTH, DEPUTY COMMISSIONER, MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH, BOSTON, MA; TARA WOOLDRIDGE, MANAGER, EMPLOYEE ASSISTANCE PROGRAM, DELTA AIR LINES, ATLANTA, GA; AND DEAN ROSEN, SENIOR VICE PRESIDENT OF POLICY AND GENERAL COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. LIBERTOFF. Thank you very much, Senator Jeffords.

I am pleased and honored to be here. I also want to express appreciation to your staff, because without their incredible diligence, I probably would have been staying in Richmond last night, because I can tell you there is not a hotel room in the area, and they were, in Vermont style, very personally helpful.

The CHAIRMAN. We take care of our constituents.

Mr. LIBERTOFF. It is much appreciated and greatly noted.

I come here today also as a member of the National Mental Health Association situated in Alexandria, VA, and that organization shares the values and the public policy goals that are outlined in my written testimony today. I just want to say that on the record.

I also want to take a moment to thank Senator Domenici and Senator Wellstone for taking the lead on the Federal parity initiative of 1996. I think they have started us down a road, and I think there is agreement as to where we want to go; it may be that there are some different ways of getting there, and I think we have now begun a very important conversation about not only what is happening in individual States but where and how we can move in terms of Federal legislation.

I just want to take 1 minute to review exactly what we were able to accomplish in Vermont and then move on to talk a little bit more about what we think some of the implications and considerations might be as you consider taking movement on the Federal level.

In January of 1998, our parity bill went into law. It was passed in June of 1997. We think this is the Nation's most comprehensive approach to insurance parity. The bill mandates that all insurance coverage in our State for mental health be equal or similar to that of physical health care. Our bill removes the traditional discriminatory barriers such as lifetime limits and annual limits that might be unequal, deductibles, copayments, coinsurance and visit limits, whether it be outpatient or inpatient. Those are all eliminated with our parity bill.

Most importantly, our bill covers all conditions and disorders for mental illness and substance abuse. There are no exemptions in our bill except for that under ERISA, which means that all businesses, large and small, from the largest companies to the single person, everyone is included in our bill.

I wanted to move in the minutes that I have to talk not only about the framework of our bill, but to talk a little bit about the social policy implications. I do want to make clear that the Vermont parity campaign was not simply about improving insurance coverage or improving behavioral health care. In Vermont in 1997, the parity issue was a fight for civil rights.

There has been a lot of discussion already today about the issues of discrimination and stigma, and in our opinion, the comprehensive parity approach is the only fundamental way of ending discriminatory practices and stigma against people who suffer from mental health and substance abuse problems.

In Vermont, we have been trying for the last 2 years to actually change the definition when we talk about behavioral health care, because for us now, behavioral health care means mental health and substance abuse. We are linking the two together. We have looked at studies, we have listened to other people, we have heard it discussed today—the co-occurring disorders, the comorbidity of these two illnesses, mean that both have to be treated, and we think there should be coverage for both, and that is what we did in our bill.

Vermont's parity bill was designed to address the unfair and unacceptable discriminatory practices that have been prevalent in the insurance industry for decades as it relates to the treatment of mental health and substance abuse. It was our contention in 1997, and even more so in the year 2000, that anything less than comprehensive parity might best be characterized not only as partial parity, which is often referred to as biologically-based brain disorders or limited to severe mental illness, SMI, because partial parity in our terms also means the continuation of partial discrimination.

At a time when many States and the Federal Government are now beginning to explore this issue, it is our recommendation that all proposals be waived for worthiness in reducing and eliminating this fundamental civil rights barrier that confronts millions of Americans. In our opinion, the time has come to treat the diseases of mental health and substance abuse in an equal and similar fashion to that of physical health problems. To do less, in our opinion, is to fall short of the mark. And I think that what we were able to accomplish in 1997 was to test those principles and pass and implement a bill that at least addresses these issues.

Once we get quickly beyond the issue of civil rights and justice, we very quickly come to the issue of cost, and I just want to take a minute or two to address that issue. It is our experience that this is truly one of the most important issues that we have to confront when we talk about mental health parity. In Vermont, based on our experience, we actually worked very hard to deal with fact, not fiction. We were able to get a very fine actuarial study, which I have here, which was performed by Coopers & Lybrand.

What we had were a lot of assertions that the parity legislation that we were proposing—and I think I outlined very briefly that this is a very, very comprehensive bill—there were assertions by some of the opponents of the bill that the premium increase could run from 7 to 12 percent if this bill passed. There were also assertions that many people might lose their insurance as a result of

passing this legislation, and that there might be a stampede to self-insurance.

The actuarial study showed that the projected cost would be 3.4 percent for the totality of our bill, and on page 6 of my testimony—and I will not take time to go through it all—we actually have the results for the State of Vermont for the year 1998, which show a rate considerably less than 3.4 percent for most of the companies in our State, including Blue Cross/Blue Shield and Kaiser Permanente, which is no longer in Vermont, MVP, North American Preferred. Their increase was between one and 2 percent for the Nation's most comprehensive parity bill. The only area in which we got a little bit above the 3.4 percent was in companies that had no managed care.

I think it is fair to say that in our opinion, the mandated comprehensive approach is really the only sound actuarial approach. Insurance is really based on the approach of covering the greatest number of lives, and when you distort that by only looking a certain, more intense diseases, we already know that a great deal of the cost built into the insurance premium is to cover that. As a matter of fact, we would assert from looking at the experience in Vermont and probably the experience on the Federal level that most of the costs that you see projected, even for SMI bills and the partial parity bills, are not going to be very much greater if you include a bill like ours, the comprehensive parity approach.

The analogy would be in cancer treatment, if you only treated the most severe end of cancer treatment, and you cover that, you are automatically in an actuarial formula developing the most considerable expense on that end, and the rest of the treatment is relatively inexpensive.

We also found that to be true, much to our surprise, for substance abuse. We happen to fight for substance abuse for reasons that have to do with clinical correctness and to deal with the discrimination factor, but the reality is that actuarially, substance abuse is a very inexpensive part of this entire cost increase in our bill, and we have some substantiation in our results and in our actuarial study to show that.

I want to very quickly talk about a few unintended consequences that we considered, because in our State, as in many other States, the 49 other States and in the Senate, you have to consider many different options and alternatives, and one of the things that we were most worried about was the possible reduction of overall benefits if you decide to only expand coverage for certain particular areas. I guess in summary we would say, after reading the GAO report, that in fact, that is exactly what I think has happened, and this happens in State after State that I examine. There is simply a shifting—if you cover only a piece of conditions, the insurance industry and businesses will react in a way that will reduce or even eliminate coverage in nonmandated sectors.

I urge you to consider that as you look at the various variables in framing insurance policy for mental health.

The second thing that was and is of great concern to us, and I think it is of great concern to many of you, based on what I have heard this morning, is children's mental health. It was a majority priority in our parity campaign. Every condition that affects chil-

dren is covered in our State. We are incredibly proud of that. It is no great secret that many of the conditions that are listed in most of the States that have partial parity—conditions like schizophrenia and bipolar disorder, which are very serious and terrible diseases, actually do not make themselves known in terms of diagnosis until one gets to the age of 16, 17, 18, and beyond.

We can and must do better. The omission of comprehensive parity for children and adolescents was simply not acceptable to our parity coalition in Vermont, and it should not be acceptable to you.

At this point, I would also just comment that in our opinion, the bill S.796 does not adequately cover children's mental health services. It covers a few defined ones. It is good, but it is clearly not good enough, in our opinion.

Our National Mental Health Association has been very outspoken and very dedicated to the improvement of children's mental health, and if you move forward on Federal legislation, we urge you to consider this particular piece in a comprehensive manner.

There is a process that goes on that we have identified in Vermont which I would say is the distorting of diagnostic procedures to access coverage which happens when you do not take the comprehensive approach. When you begin to limit coverage to certain conditions and disorders, we have seen that the actual clinical diagnosis changes. There is often, in fact, a tendency for consumers and parents to work very hard to have their children misdiagnosed so that there will be coverage on those conditions which have parity.

The last particular issue of unexpected conditions would be the whole question of regulated managed care. In our State, we knew that managed care would be part of our parity legislation. Managed care is a technique. In some areas, it does well; in other areas, it needs improvement. We have been working very hard to create some regulatory structure for our managed care industry in our State that we are very proud of. We sit with them at the table. But without some type of regulatory control over managed care, parity bills can easily be gutted, based on our experience in Vermont.

I will just point to two or three very recent developments that I would bring to your attention. One is the incredible development in the last 18 months in a variety of States for the passage of various parity proposals. The action really did shift from Washington to Montpelier, VT, and to State capitals across the country. But there is now a patchwork quilt of all kinds of different coverage. We think it is time to unify those in a Federal approach.

I think the Surgeon General's report is a second important component. It has endless information and data about the importance of parity and treatment.

And last but not least, in 1999, the President unveiled the Federal Employees' Health Benefits Plan which we see as a terrific model of comprehensive parity for all State employees that will take effect by the year 2002, covering mental health and substance abuse. We think that that is an exciting model to work from.

In closing, I would say that we are living in an age of incremental health care reform. Now is the time, and the U.S. Senate is the place, to address this fundamental civil rights issue. There are many models and many ideas on the subject. We think the Ver-

mont parity legislation of 1997 is a fine standard for national consideration.

Thank you very much.

The CHAIRMAN. Thank you for your excellent statement, and I agree with you.

[The prepared statement of Mr. Libertoff follows:]

PREPARED STATEMENT OF KEN LIBERTOFF

Mr. Chairman and Members of the Senate Health, Education, Labor and Pensions Committee: I very much appreciate the invitation to testify before you today on the issue of mental health parity. I will try, in my brief remarks, to share with you our experience in Vermont where in 1997, we passed the nation's most comprehensive parity bill for mental health and substance abuse. It is also my hope and expectation to identify some of the lessons we have learned from our experience with the hope and expectation that they have some relevancy to the debate on federal parity legislation.

SECTION I: THE VERMONT STORY

On the morning of January 5th, 1998, as I sat in my downtown Montpelier office, I received a telephone call that was both very poignant and very familiar. It was a call from a mother of a sixteen year old daughter who had been experiencing, over the past three years, a variety of serious behavioral health care problems that ranged from depression, bulimia, an unsuccessful suicide attempt and episodes of alcohol abuse.

Both parents of this daughter were working Vermonters with their health insurance covered through the father's employment in a company of some twenty employees. For a decade, they had been able to secure the best policy offered by Vermont Blue Cross/Blue Shield (BC/BS) of Vermont. The best that BC/BS had to offer was good but certainly not good enough. Despite having a million dollars of lifetime insurance and full, comprehensive coverage for all physical health conditions, their coverage was limited to $10,000 lifetime for mental health treatment. Their policy also carried with it annual limits on coverage as well as higher co-payments and deductibles for behavioral health as compared to physical health.

This telephone call was all-too-familiar because over the course of the past fifteen years, I had, as director of the Vermont Association for Mental Health, a private, non-profit citizens' organization, fielded hundreds of calls and many visits from people with serious and oftentimes dramatic concerns about their coverage for mental health and substance abuse treatment. Anguish and tears were not uncommon. Most of these folks not only had the "horror" of coping with a very sick loved one but they also confronted the reality that they and their families might be on the brink of a financial catastrophe.

The mom who called me on January 5th, 1998 was very emotional and, in fact, within a few minutes of the conversation, she had to take a moment to collect herself because of the strained circumstances. In September of 1997, her daughter had reached her lifetime cap of $10,000 for mental health treatment, fueled in part by two residential treatment experiences, and during the latter months of 1997, the family had recently paid thousands of dollars out-of-pocket in order to be able to continue treatment. The Mom reported that although her daughter had shown some improvement, the medical treatment people were clear in advising that further intervention was needed. There was no way they could continue to pay for the treatment from their own resources.

This mom had heard and read a news account that appeared on January 1st of 1998, that indicated that Vermont's new, comprehensive parity law for mental health and substance abuse was now in effect. As she understood it, this bill was intended to end all arbitrary discriminatory practices in the construction of health insurance as it involves behavioral health care treatment. Her question was simple, "Does this mean that my daughter now has the potential of having her insurance cover treatment for the conditions that she has whether it is depression or substance abuse"?

The poignancy of the moment did not escape me. Many of us had worked in Vermont for more than a decade to be able to give an answer without a great deal of pause or reflection. My answer was a very simple "yes"; there are, as of the 1st of January 1998, no more arbitrary lifetime or annual limits, no high deductibles or co-payments, and no restrictions on either in-patient or out-patient care. In addition, I could assure her of the following: All conditions for mental health and substance

abuse would be included; her daughter's new lifetime limit would be the same of that for physical health care; and Vermont's legislation enables the Mom, daughter and family to focus on the task of getting better rather than confronting the realities of discriminatory insurance practices that reduce access to appropriate care and raise the prospect of financial chaos.

The poignancy of the moment did not escape me. While the mother thanked me profusely and emotionally, well beyond that which was necessary or appropriate, I discovered that she was not the only one who had to wipe a tear from their eye.

Fighting successfully for parity, comprehensive parity, was well worth the battle.

SECTION II: DESCRIBING THE VERMONT COMPREHENSIVE PARITY BILL

Vermont's Mental Health and Substance Abuse Parity Law (Act 25) Brief Overview

Vermont's parity law is simple in form and design. It ends, by mandate, all discriminatory practices in the construction of health care benefits for mental health and substance abuse treatment.

Under the provision's of Vermont's parity law, all health insurance policies in Vermont treat the body and the mind in a similar fashion, making little, if any, distinction between benefits for physical health and mental health. This is a bill built on a foundation of inclusion. There are no loopholes or exclusions beyond those allowed under the Employee Retirement Income Security Act (ERISA).

Further highlights and components of the bill are listed below:

A health insurance plan must provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. This legislation marks true fiscal parity for mental health and substance abuse treatment.

Rate, term or condition' means any lifetime or annual payment limits, deductibles, co-payments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

The Vermont parity bill defines "mental health condition" as meaning any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories.

The Vermont law permits but does not require the use of managed care for mental health. In order to balance the concerns of both proponents and opponents of the legislation, the Vermont bill allows for managed behavioral health care even if there is not a corresponding management component for the physical health care provided in any particular health insurance plan.

Vermont's parity bill went into effect on January 1, 1998 or as consumers reached their anniversary date for health policy renewal. Previous collective bargaining agreements were also recognized and honored.

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) is the state agency charged with the responsibility of monitoring the implementation of the bill. The law specifically states that a managed care organization must be in compliance with rules adopted by the commissioner of Banking, Insurance, Securities and Health Care Administration and assures that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this law.

SECTION III: THE FRAMEWORK OF THE VERMONT PARITY BILL AND IMPLICATIONS FOR SOCIAL POLICY.

1. PARITY AS A CIVIL RIGHTS ISSUE

The Parity campaign in Vermont was not simply about improving insurance coverage or improving behavioral healthcare treatment. In Vermont, the 1997 Parity initiative was a fight for civil rights.

When Vermont's Governor Howard Dean signed the parity bill into law on June 10th of 1997, the state made a profound commitment to end discriminatory practices by the insurance industry against all consumers and subscribers in Vermont's private healthcare market.

In confronting this discrimination, the Vermont bill attempts to redefine the meaning of behavioral healthcare to include not only mental health but substance abuse treatment as well. Indeed if there is reference to the "Vermont model of Parity", acceptance of this definition is of critical importance.

Vermont's parity bill was designed to address the unfair and unacceptable discriminatory practice that has been prevalent in the insurance industry for decades as it relates to the treatment of mental health and substance abuse disorders. It was our contention in 1997, and it is even more of a contention in the year 2000,

that anything less than comprehensive parity might best be characterized not only as "partial parity" (often referred to as biologically based brain disorders or severe mental illnesses) but as the continuation of "partial discrimination".

At a time when many states and the federal government are exploring this issue, it is our recommendation that every and any proposal be weighed for its worthiness in reducing and eliminating a fundamental civic rights barrier that confronts millions of Americans today. The time has come to treat the disease of mental health and substance abuse in an equal and/or similar fashion to that of physical health problems. To do less, in our opinion, is to fall short of the mark.

2. THE FINANCIAL COST OF PARITY

The Parity campaign in Vermont may have been framed as a civil rights or social justice issue but for most participants, the key question was the probable cost of our legislation. Without reliable cost projections, it is unlikely we could have moved the debate forward.

"How much will it cost?" In 1996 we had little specific data about Vermont. Neither did other players in the debate including leading insurance companies and representatives of the state's business groups. One thing that we did learn was that there was a need to focus on facts and statistics rather than vague and sometimes inaccurate projections based as much on political positioning as on actuarial analysis. Despite claims from opponents (of Vermont's comprehensive bill) that the premium increase might be as high as 7%—12 %, we were able to secure a thorough actuarial analysis performed by Coopers & Lybrand in early 1997 that focused solely on Vermont. The actuarial report suggested a probable 3.4% increase for comprehensive parity as outlined in the Vermont legislation. This projection turned out to be accurate although initial first-year reporting suggests an even lower cost impact than anticipated.

Having spent two years examining the cost of parity in Vermont and the costs in other states, it is our belief that in fact, a mandated, comprehensive approach represents a sound actuarial decision for the investment of "precious healthcare dollars". In 1996, the Congressional Budget Office estimated that a more partial parity approach (such as a parity bill that has limited diagnosis based mental illness) costs 90% of comprehensive parity. Partial parity legislation defies much of the logic and operating principles associated with insurance. If one is primarily covering "high-end" diseases for mental health treatment (or for a medical disease like cancer), one not only discriminates in favor of high profile and highly intense interventions but this approach carries with it significant cost and expense considerations.

As articulated earlier, the decision to include substance abuse treatment in Vermont's parity bill reflected greatly on our desire to craft a new definition for behavioral healthcare in our state, meaning both mental health and substance abuse. But the actuarial findings were not only instructive but encouraging. In terms of dollars and cents, insurance coverage for the disease of alcohol and substance is rather "inexpensive". Based on the actuarial projections of the Coopers & Lybrand study (January 1997), we had a high degree of confidence that any fiscal argument against the inclusion of substance abuse were unfounded.

3. UNINTENDED CONSEQUENCES

The Parity campaign in Vermont did consider, in 1996, many different models ranging from comprehensive parity with and without substance abuse, as well as a variety of diagnostic based parity approaches with both short and longer lists of covered conditions in severe mental illness (SMI) parity. The more we analyzed the situation, the more worried we became about taking a course that would result in unintended consequences. We came to believe that the way to avoid these unintended consequences was to support a comprehensive parity bill.

A. Possible reduction in over-all benefits as a result of expansion in certain sectors.

The goal of parity legislation is to expand access to behavioral healthcare treatment. Yet the fear of unintended consequences of the partial parity approach made us uncomfortable. We believed that one probable outcome of the partial parity (SMI) approach would be the prospect of seeing the market adjust by actually reducing or even eliminating coverage for all those conditions not designated for broader parity. It appears that this unintended consequence may be identified in the U S General Accounting Office findings about the impact of the federal Mental Health Parity Act of 1996 which suggests there was a reduction in some benefits to accommodate the required enhancements. This "offset" factor should be a serious concern for those who want to increase access to mental health in an incremental fashion.

B. Neglecting Children's Mental Health in Parity.

One major priority in our campaign of 1997 in Vermont was our desire to make sure that children and adolescents would have access to parity for both mental health and substance abuse treatment. From our vantage point, one unintended consequence of the partial parity approach, one which has been adopted by a majority of the states in the past five years, is that it generally omits many conditions that impact young children or teenagers. Schizophrenia and bipolar disorders are two prime examples of "biologically-based" conditions that are not commonly diagnosed in those under the age of 18 years. The omission of comprehensive coverage for children and adolescents was simply not acceptable in the Vermont parity plan. Federal parity legislation should, in our opinion, set the same standard.

C. Distorting Diagnostic Procedures To Access Treatment

Another major concern we encountered as Vermont considered the best approach for us was the likelihood that partial parity legislation might encourage, in fact lead to, a systematic change in the way conditions and diseases are diagnosed in behavioral health care treatment plans. Moving quickly from theory to practice, when some health conditions "enjoy" parity status, and therefore accessability to treatment is enhanced, there is a strong tendency to see a distortion in the diagnostic process. Certainly it is not an unknown reality in health care but the design of partial parity is an invitation for what I will call "improper diagnostic creep". This is one reason we worked so hard to include alcohol and substance abuse coverage which is oftentimes a co-occurring disorder. It is time to enhance good clinical practice in behavioral healthcare rather than perpetuate or encourage a system that distorts diagnoses (upgrading diagnostic evaluations) as a strategy to access more expansive treatment.

D. Unregulated Managed Care Can Undermine Parity Legislation

In Vermont, it was our assumption that the passage of our comprehensive parity bill would result in an expansion of managed care in the field of behavioral healthcare treatment. In reality, this would have happened even if we had not passed such an expansive bill because managed care has become a standard in the delivery of behavioral healthcare throughout much of the nation.

Managed care is a technique for rationing access to health services. It is, in our opinion, a very young industry. In reaction the early Vermont experience with managed care companies, we passed, in 1994, a model regulatory bill aimed at providing controls and oversight over the industry. There has been concern that left unchecked, managed care companies might hold such power as to negate the very core goals of our parity legislation. In fact, Vermont has experienced problems over the way in which managed care companies have performed since January of 1998. Our concerns recently led us to propose and pass additional regulatory controls over managed care companies which we believe will address some important questions, questions about the amount of dollars that are being invested in behavioral healthcare treatment both before and during the "parity years" as well as the introduction of a rating system that might better capture the strengths and weaknesses of insurance and managed care companies in their behavioral healthcare work in Vermont.

SECTION IV: SIGNIFICANT RECENT DEVELOPMENTS

Over the course of the last six years, there has been major progress made in expanding insurance coverage for the diseases of mental health and substance abuse. During this period, much of the initiative for parity legislation has moved from the halls of Congress to statehouses across America including Montpelier, Vermont, Santa Fe, New Mexico and Annapolis, Maryland. Fives states now have passed comprehensive parity bills that include both mental health and substance abuse. While a majority of states have, during the last six years, passed limited "partial parity" bills, they differ greatly in scope, design and vigor. And there are nearly twenty states with no parity legislation of any type at all. Incremental though this may be, it is a start. However this is a "patch-work" quilt of activity. It is time for a clear and expansive statement from Congress on the parity issue.

The recent publication of the Surgeon General's Report is the first document of its type to focus on mental health in America. This report clearly recommends that mental health should have parity with physical health coverage.

On June 7th 1999, the President unveiled the Federal Employees Health Benefits Plan (FEHBP), granting all federal employees and their dependents comprehensive parity (for mental health and substance abuse) by the year 2002. This decision is of major significance not only because it will cover more than nine million people

but it sets a new federal standard for comprehensive parity. If this can be achieved for federal employees, other Americans deserve nothing less.

SECTION V: BRIEF CONCLUSION

We are living in an age of incremental health care reform. Now is the time and the United States Senate is the place to address a fundamental civil rights issue—that of parity for the diseases of mental health and substance abuse. There are many models and many ideas on the subject. We think that the Vermont Parity legislation of 1997 offers a fine standard for national consideration.

The CHAIRMAN. Dr. Duckworth.

Dr. DUCKWORTH. Thank you, Mr. Chairman, Senator Dodd, Senator Wellstone. I cannot imagine a more compelling birthday present than to spend 5 minutes talking about something that I feel very passionate about, and this mental health parity bill is something I care very deeply about.

I would like to start by quoting a very famous health policy analyst, Yogi Berra, who said: "You can learn a lot by watching."

I have been a psychiatrist in a community mental health center in Boston for 13 years, taking care of children, adolescents, adults, and I have also done some prison work. I have formulated some definite impressions about how people come to construct their thinking around psychiatric illness. I would like to make a few points very clear as a doctor.

People rarely thank me for making a diagnosis. They rarely say, "I am so delighted to have this serious psychiatric illness. Now I would like to go and use as many benefits as possible."

People usually have a normal response, which is, "Gee, I was hoping that my perception of reality was on target, or that these symptoms were explainable by anemia or something that has no social stigma." The idea that the brain might have a chemical imbalance in some way is extremely powerful and troubling for people to take in.

So in addition to that kind of natural human response, which I respect and understand with all of my patients, we have introduced a patchwork of service barriers making it difficult for people to access that.

There is some literature which suggests that people with schizophrenia do not appreciate that they have the condition about 50 percent of the time. So now we have a person who may not appreciate that their perception of reality does not jive with other people, and we introduce limitations on how well they access services. I think there is little surprise, then, that we result in a situation where people delay treatment, which worsens the course of their illness, and they do not have access to treatment as soon as possible.

I would like to share a few vignettes with you from my own clinical practice, from watching what people have done. In one case, a man comes to me and asks, "How do I explain this gap on my resume?" After a remarkably robust response to treatment, he feels that he will be stigmatized and will not be reemployable if he decides to reveal that he has a psychiatric illness.

Another man said, "I currently work for an enlightened employer who will cover my condition, but I am thinking about changing jobs because I have an opportunity to step up, and I feel very deeply that my obsessive-compulsive disorder will not receive adequate

treatment because the doctor, whom I trust and who understands what I am doing, is not on the panel for the new employer."

"Doctor, would you consider changing my diagnosis to something that is less stigmatizing? Would you call this depression fibromyalgia?"

These are all examples of ways in which people are struggling with the reality that psychiatric illnesses do have a low social status, which is the definition of "stigma."

I would like to also say that in my role as a teacher at Harvard, the trainees that I am working with now have a profound appreciation of value and cost which they never had before. When I was training, people resented any question of was this the best use of resources or money. That was considered an outrage. Our job as doctors was to give people everything at all times—so what else could there be?

Really, it was like we were driving a car that had only first gear, which would be inpatient hospitalization, and then outpatient care. I think that over time, we have seen that there are now partial treatments, employment treatments; there is more of a gradation of care which meets people where they are.

So I think the trainees now will be a natural break in addition to managed care on the cost side of this, because they are very conscious now—it is part of their training in medical school, which was not the case with mine just 14 years ago—is this the best use of this health care dollar? They think about it all the time.

I would like to mention a brief personal experience around this whole issue. Two illnesses run very strongly in my family—life is rather ironic—cancer and psychiatric illness are the two things that afflict my family. I am sure the next family has other things—perhaps asthma and diabetes, or psychiatric illness and Lou Gehrig's disease.

I had cancer 10 years ago, and I was very impressed with the social response to this condition. I was presumed to be a heroic figure battling a dread disease. I was presumed to be a good person, and I was given every support that a man could imagine from my employers, from my colleagues, from my friends. I was given tuna noodle casseroles. I often give talks to psychiatrists about the important problems around stigma, and I ask for a show of hands if any of them have ever had a patient leave a psychiatric facility and be given flowers, casseroles, or any kind of support. I never see a show of hands at all. This is because the social status of psychiatric illness is low—it is low. It is considered something that perhaps you have done to yourself or something that you wished upon yourself. The idea that the most complicated organ, the brain, can become disordered is troubling for people to acknowledge, but that the insurance coverage should be different for those conditions than for psychiatric conditions is really appalling, from my point of view.

With the psychiatric illnesses that travel in my family, people have not received the same level of thoughtful concern and caring—it is interesting—and the social attitudes are reflected very directly in their insurance problems. All sorts of hurdles and barriers are created for people to access the services, and they are just not treated in the same natural way as basically deserving of a worthy health care role.

I think this is exactly the role of the Federal Government, which is to create a floor of civil rights protections for discriminated classes. People do not choose to have their pancreas become disordered and get diabetes. People do not choose to have their prefrontal cortex disordered and develop schizophrenia.

I am the father of three children, and I am aware, based on what we know about science and what we do not know about science, that there is no test that I can give any of the three of them for either cancer or psychiatric illness. However, as a decent clinician, I am aware that my children are at tremendous risk for both of those conditions. If you look at the family trees on both conditions, it is quite remarkable.

The idea that if the children developed one condition, perhaps cancer, they would be treated with full insurance and respect, or a different condition, such as bipolar illness or manic depressive illness, that they would be treated differently if they were to develop those conditions is really appalling.

I am extremely grateful for your leadership, Senators Wellstone and Domenici, Senator Jeffords, and Senator Dodd, on this important issue. I happen to believe that every step the Federal Government can take in this regard to help people with very powerful and painful catastrophic illnesses receive the social understanding and support that they deserve, as exemplified by insurance coverage, makes a statement across the board that is not just fiscal but is also social. And I am very grateful for your efforts in this direction.

Thank you.

The CHAIRMAN. Thank you for an excellent statement.

Senator WELLSTONE. Thank you.

[The prepared statement of Dr. Duckworth follows:]

PREPARED STATEMENT OF KEN DUCKWORTH, M.D.

Mr. Chairman, Senator Kennedy, and members of the Health, Education, Labor, and Pensions Committee.

I am here to testify in strong support of full parity for serious psychiatric illness such as would be advanced under the Mental Health Equitable Treatment Act (S. 796) introduced by Senators Domenici and Wellstone.

As a clinical psychiatrist in an academic community mental health center for 13 years, I have seen the negative effects of insurance discrimination on people with catastrophic psychiatric conditions, and how this bias contrasts with other illnesses. Full parity redresses a number of inequities that are arbitrarily imposed on people because of their illness "status", and does so at minimal, to no cost.

This action is warranted at this time, as our neuroscience knowledge base has expanded dramatically in the past two decades helping us, as a field, to better understand the underpinnings of disorders of the brain. At the same time, our profession has come to understand that people require cost-effective services—those that produce the best outcomes for the scarce resources utilized. This pressure toward accountability has fortunately intensified uses of alternatives to expensive hospitalization, and has increased training efforts to get people back in to the workforce as quickly as possible during their treatment. This professional change is important, as brain disorders are a substantial, and growing cause of disability and lost workdays in the United States.

I have witnessed the discrimination that full parity redresses personally, as well professionally. As a family man with three children, I faced a catastrophic and potentially life threatening illness. This illness was cancer—the response I received in our society was of support and encouragement. Not surprisingly, my insurance coverage mirrored this view of my illness as "legitimate." Over $250,000 was spent on my chemotherapy and surgeries, with minimal cost to myself I was, and am, very grateful for a medical system that helped me to live and to do so with dignity and without catastrophic financial loss.

Yet another family man with three children I know had a different kind of illness bipolar, also known as manic-depressive illness—and received a very different response both from society and the insurance industry. I know this story intimately, as that family man is my father. His illness isn't based in the immune system as was mine; it is based in his brain. Yet this minor biologic difference resulted in grossly different treatment by friends, church members and, notably, the insurance industry. During my childhood, his condition was never talked of openly; his problems were presumed to be of his own making. Indeed, people acted like this neurochemical deficit was almost contagious. These fearful attitudes were reflected in his insurance policy, which did not cover him in any way as I had been. For my father, this discrimination resulted in lost days of productivity, financial loss and unnecessary human suffering.

Full parity is therefore the logical extension of our increased knowledge base about catastrophic brain disorders that afflict children, adolescents, and adults. My experience as a clinician teaches me that people's fears and attitudes about people with these brain disorders lags behind our understanding of these conditions by several decades, In a 1998 survey that I designed involving 400 randomly selected Massachusetts residents, 2 out of 3 people questioned thought schizophrenia was the same as "split personality" - it is not. Additionally, 90 percent agreed with the statement that, "because of shame, people do not seek help for psychiatric conditions." The respondents consistently felt they were more likely to seek help for a less stigmatized condition, such as heart disease. These kinds of misunderstandings and attitudes fuel the stigma associated with psychiatric illness. This stigma causes people to delay seeking help, which worsens their long-term prognosis, and increases the days they cannot function as effective workers, family members, and citizens.

Insurance policies that create barriers to accessing these services compound and reinforce these negative and skewed social attitudes. By legislating protections for these conditions as worthy of the same status as other biologic conditions, such as diabetes or cancer, we, as a society, legitimize the chance that the clinically depressed executive will get the help he needs to return to his former level of functioning in a briefer period of time, or that the suicidal 12-year-old will have easy access to a clinical assessment.

Dr. David Satcher, our Surgeon General, has identified suicide as a growing and important public health crisis. He is the first Surgeon General to do so, and his report makes the connection that the vast majority of suicides occur in the context of psychiatric illnesses. As a clinician, my experience is that the suffering that attends a suicide lasts for a lifetime for those left behind. This bill is one important step towards ending discrimination toward people with the conditions most likely to result in suicide.

In my State of Massachusetts, a mental health parity bill was recently signed after years of debate and struggle. Like 30 other states, the Legislators of Massachusetts correctly recognized the fundamental discrimination inherent in current widespread insurance practice, and corrected it. This is something that we as a mental health field intend to carry out in a cost-effective way, as we have done for the Massachusetts State employees who have enjoyed this benefit for years prior to the statewide bill recently enacted. Yet many states have no protection for people with biologically based brain disorders. Voluntary efforts by individual businesses to improve mental health access and coverage are laudatory but fail to ensure a floor of protection for America's workers, who rarely work with one employer for their entire career. Full parity at the federal level ensures equal coverage across all places of work for people who suffer with these challenging conditions.

My experience as a doctor, patient and family member corroborates what the neuroscience and cost data reveal: Full parity is just, affordable and will make a difference for millions of Americans and their families. Thank you.

The CHAIRMAN. Ms. Wooldridge.

Ms. WOOLDRIDGE. Mr. Chairman, Senators of the committee, I am pleased to have this opportunity to speak to an issue which is very important to me personally as well as to my corporation.

Delta is a leader in the transportation industry, serving the largest number of nonstop markets of any U.S. airline. Company success results from the efforts of 75,000 employees. Delta provides health care, including mental health and substance abuse care, for more than 165,000 employees, retirees, and family members. Delta prides itself in being a company that exemplifies best practices in employer-sponsored health care. We offer generous health and be-

havioral health benefits to our employees and their families. There are no separate annual or lifetime limits on mental health treatment, nor do we have any day or visit limits and have worked hard to eliminate all barriers to appropriate, timely service. Surveys of employee satisfaction suggest that they are pleased with their health benefits.

We provide these benefits because they are consistent with the best interests of our company. Delta's success depends on ensuring the safety of our customers, and that depends on the productivity and health of our employees.

We believe there are limitations to the capacity of parity laws to address this goal. Legislation focuses solely on benefit design which is only one aspect of the complex question of providing access to quality mental health and substance abuse care for employees and their families.

The other factors include ensuring adequate care delivery systems,, plan management, and combating the persistent stigma against seeking care even when it is available.

The important message from large employers like Delta is that in the past decade, we have introduced and implemented generous mental health and substance abuse benefits for our employees, not in response to legislative mandate, but because it improves our corporate bottom line.

It is important to not that Delta and other large employers have extensive corporate resources to devote to the complexities of providing quality behavioral health care. Our experiences and views are by no means typical or representative of all employers in general. Many small companies cannot afford to provide as much, and certainly, employees cannot afford coverage.

Mental health and substance abuse coverage has long been characterized by limits that do not apply to health coverage generally. The strong support for parity in mental health benefits exists on the grounds of basic equity and treatment for individuals with mental or addictive illnesses. But from Delta's perspective, it is even more important to recognize that failure to identify and treat mental illness and addiction imposes great costs and emotional burdens on individuals and their families, and it results in lost productivity as well as potential safety hazards.

In 1994, Delta turned to care management tools as a better way to provide mental health and substance abuse care for our employees. Our goal was to ensure timely access to comprehensive, quality care. Looking simply at the cost of treatment did not recognize the much greater cost to our company when employee dependability and functioning were impaired as a result of mental or addictive disorders.

We also realized that failure to diagnose and appropriately treat mental illnesses, in particular depression, resulted in high levels of absenteeism, related health care costs, and reduced productivity at work. Published studies confirmed our own experience. Employers who use benefit design to tightly limit access to mental health care did not experience overall savings, because they had higher psychiatric disability and medical costs and productivity losses, while companies with less restricted access to outpatient mental health services had lower disability rates.

In contracting for managed behavioral health care, our primary focus was not on limiting cost but on managing care to assure that employees received substantially unlimited access to appropriate care. This meant providing a continuum of care with access to intermediate levels of care and outpatient therapy, using after-care and outpatient treatment to reduce readmission and relapse. There was also a need for mechanisms for access and referral to appropriate treatment.

Prior to the passage of the Parity Act, many analysts expressed concern that it would be costly. However, we have found that through the use of appropriate care management, we have been able to ensure employee access to high-quality services without cost increases—in fact, with some cost savings. Recent actuarial cost-prediction models are consistent with our own experience.

At Delta, where we had generous but unmanaged fee-for-service benefits, our costs went down. This was primarily because our employees received more services in lower cost outpatient and alternative care programs, and spent less time in high-cost inpatient and residential treatment.

At the same time, we believe that the care employees received was better-tailored to meet their needs and more focused on assisting them in returning to productive functioning.

Delta is also making a concerted effort to assess the impact that mental illness and addiction disorders have on employee productivity. Data suggest that depression and other mental illnesses account for more employee disability days than any of the other major causes of disability, like diabetes and heart disease. Our company's experience is entirely consistent with many studies of the impact of depression on productivity.

It is important for us to introduce depression awareness and education programs to encourage our employees and their families to seek appropriate treatment. Doing so is cost-effective for our company.

It is important that we also address the stigma. For Delta and other large employers, the goal continues to be on focusing on employees getting the right kind of treatment, that is appropriate and that is comprehensive. To address this issue, Delta has enhanced and strengthened our employee assistance program to focus on programs to increase health awareness and promote early intervention. We also work toward eliminating stigma while addressing employee concerns about information sharing and confidentiality.

As a result of strengthening the EAP, we have found that employee utilization of mental health benefits has doubled. At the same time, a significant offset exists in greater productivity and reduced sick leave and disability costs. We recognize that we must continue to address stigma on not only a corporate level but a national level as well.

Parity laws tend to focus on reducing benefit plan barriers to access but not the quality of care issues. That is of primary importance—access to quality care across the board. Delta is a strong advocate of the goal of expanding employee access to high-quality services. We firmly believe appropriate treatment of mental and addictive disorders is essential to productivity in the workplace, is cost-effective, and is vital to our employees and their families.

However, we recognize that everyone does not have the resources that we have within our company. We would hate to see legislation create other tragic consequences. It is our hope that we can work toward providing good access to quality care for everyone in our Nation across-the-board.

The CHAIRMAN. Thank you. You must be so proud of Delta—I am—to have led the way in demonstrating that it can be a successful venture. Thank you for your testimony.

[The prepared statement of Ms. Wooldridge follows:]

PREPARED STATEMENT OF TARA WOOLDRIDGE

I. Introduction

Mr. Chairman and Senators of the Committee: Good morning. I am Tara Wooldridge, Manager of the Employee Assistance Program for Delta Air Lines. Delta is a leader in the transportation industry, serving the largest number of nonstop markets of any U.S. airline. Delta is a leader across North America as a result of the efforts of almost 80,000 employees. The Company provides employer-sponsored health care, including mental health and substance abuse care, for more than 165,000 employees, retirees, and family members. While our home office is located in Atlanta, Georgia, we have employees at job sites throughout the United States as well as internationally.

Delta prides itself in being a company that exemplifies best practices in employer-sponsored health care, including mental health and substance abuse care. We offer generous health and behavioral health benefits to our employees and their families. There are no separate annual or lifetime limits on mental health treatment. We do not have day or visit limits for mental health treatment and have worked hard to eliminate all barriers to appropriate, timely services. Our surveys of employee satisfaction with their behavioral health benefits suggest that they are pleased with the benefits they receive.

We provide these benefits because they are consistent with the best interests of our company. Delta's success depends on ensuring the safety and comfort of our customers, and that depends on the productivity of our employees. Provision of quality mental health and substance abuse benefits is essential to employee productivity,

Delta supports the goal of working to improve and expand coverage for mental and addictive disorders. However, we believe that there are real limitations to the capacity of the Mental Health Parity Act of 1996 or other parity laws to address this goal. Such legislation focuses solely on benefit design, which is only one aspect of the complex question of providing access to quality mental health and substance abuse care for employees and their families. Those other factors include ensuring adequacy of the care delivery systems, plan management, education to foster recognition of symptoms of mental illness and combating the persistent stigma against seeking care, even when available. Ensuring access to quality care requires an array of tools: generous benefits, appropriate care management techniques, employee education and application of performance measures to assess quality of care. In our view these complex issues are not necessarily suited to legislative solutions.

The important message from large employers like Delta is that in the last decade we have introduced and implemented generous mental health and substance abuse benefits for our employees and their families, not in response to legislative mandate, but because it improves our corporate "bottom line," Delta is a member of the Washington Business Group on Health. WBGH is a non-profit membership organization supported by large employers like Delta, who are involved in public and private efforts to improve health care, including behavioral health care, delivery. Earlier this year, we along with AT&T, Eastman Kodak, American Airlines, Pepsico, IBM, GM, and the Massachusetts Group Insurance Commission participated in a WBGH project to assist the U.S. Office of Personnel Management (OPM) in planning for the implementation of mental health and substance abuse parity in the Federal Employees Health Benefit program. (OPM is also a WBGH member.) Although these companies have varying views on parity and generous, but diverse, mental health and substance abuse benefits, we were willing to share our experiences and best practices in the management of behavioral health benefits for our employees and their families with OPM, as it undertook its planning for implementation of mental health and substance abuse benefits to more than 9,000,000 federal employees, retirees, and their families.

It is also important to note that Delta, as well as these other large employers, have extensive corporate resources to devote to the complexities of providing quality behavioral heath care to their employees and their families. Our experiences and views are by no means typical or representative of employers in general, most of which are much smaller, than Delta Air Lines. Many of those employers may continue to purchase behavioral health care that still uses deductibles; limits and other demand-side mechanisms to limit access to mental health treatment.[1] Differences may be attributed to the real disparity in resources between large, self-insured employers and smaller companies. The value of parity is not diminished at these companies but the best methods of providing needed resources may vary.

A. Delta's Decision to Provide Generous Mental Health and Substance Abuse Benefits—The Business Case

Background:

Mental health and substance abuse coverage has long been characterized by limits that do not apply to health coverage generally. The support for parity in mental health benefits has been strongly supported on the grounds of basic equity in treatment for individuals with mental illness or suffering from addictions. But from Delta's perspective it is even more important to recognize that failure to identify and treat mental illness and addiction imposes great costs and emotional burdens on individuals and their families, and results in lost productivity. Further, the success of administrative, financial and care management mechanisms used by managed behavioral health care firms has demonstrated that costs can be held down while providing an expanded scope of services and better continuity of care compared to unmanaged indemnity plans.[2]

Delta's Care Goals: Ensuring Access and Productivity:

In 1994, Delta turned to care management tools as a better way to provide mental health and substance abuse care to our employees. Our goal was to ensure that employees had timely access to quality care. Like many other employers, we began to realize that looking simply at the cost of treatment did not recognize the much greater costs to our company when employees were absent from work or at work with impaired functioning as the result of mental or addictive disorders.

We also realized that failure to diagnose and appropriately treat mental illnesses, in particular depression, resulted in high levels of absenteeism, related health care costs, and reduced productivity at work. Employees who were coping with untreated illness experienced by family members were also adversely affected at work. Published studies confirm the adverse impact of untreated mental illness on employee productivity. Studies also confirmed that employers who used benefit design to tightly limit access to mental health care did not in fact experience overall savings, because they had higher psychiatric disability costs and productivity losses; while companies with less restricted access to outpatient mental health services had lower disability costs. Similarly, companies that limited access to mental health treatment experienced higher medical care Costs.[3] Delta also believes that substance abuse treatment must be included as part of an appropriate overall behavioral health program, particularly in light of the findings that the incidence of co-occurring mental and addictive disorders is as much as 3% of the U.S. population.[4]

Access and Care Management:

Thus, in contracting for managed behavioral health care, our primary focus was not solely on reducing treatment costs—but also on managing care to assure that employees received substantially unlimited access to appropriate care. This meant that there had to be a continuum of care with access to such intermediate care modalities as halfway houses, community-based services, intensive outpatient treatment, and partial hospitalization in addition to traditional inpatient hospitalization or residential treatment and outpatient therapy. It also meant that inpatient treatment needed to be followed by aftercare and programs of outpatient treatment to reduce readmission and relapse. There also needed to be mechanisms for access and referral to appropriate treatment.

We required our care management vendor to be responsible for developing and contracting with a network of appropriately licensed and trained providers, individ-

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[1] R. Sturm and J. McCulloch, (1998) "Mental Health and Substance Abuse Benefits in Carve-out Plans and the Mental Health Parity Act of 1996," Journal of Health Care Finance 24(3), 82–92.

[2] U.S. Dept. of Health and Human Services (1999), Mental Health: A Report of the Surgeon General, 411–428.

[3] D. Salkever (1998), Predictors and descriptors of psychiatric duration, cost and outcomes study, UNUM Life Insurance Company, Portland, Maine; M. Olfson, et at, "Mental Health/Medical Care Cost Offsets: Opportunities for Managed Care," Health Affairs 18(2): 82-86; M. J. England, "Perspectives: Capturing Mental Health Cost Offsets." Health Affairs 18(2), 91-93.

[4] Report of the Surgeon General, 46.

ual treatment practitioners and facilities, who could provide the services needed by our employees and their families. We expected that all our employees and their families would have access to appropriate treatment with reasonable waiting times for treatment depending on urgency of care, as well as access to providers located within a reasonable distance. And we require our vendor to provide us with data to measure such access to care. The licensed clinicians in the Employee Assistance Program (EAP) evaluate the data and recommend changes as appropriate to ensure timely access to quality service.

The Impact of Expanding Access to Care on Cost:

Treatment costs

Prior to passage of the 1996 Parity Act, many analysts expressed concern that the introduction of parity mental health benefits would be very costly. However, we found that through the use of appropriate care management we have been able to ensure employee access to high quality services without cost increases. More recent actuarial cost-prediction models are also consistent with our experience, concluding that costs associated with mental health parity are controllable. A 1998 report by the National Advisory Mental Health Council found that in systems already using managed care, implementing parity results in a minimal (less than 1 percent) increase in overall health care costs during a one year period. In addition, in systems not using managed care, introducing parity with managed care can result in a substantial reduction in total mental health costs. [5]

At Delta, where we had generous, but unmanaged, fee for service benefits, our costs went down with the introduction of parity coupled with management. This was primarily because our employees received more services in lower cost outpatient and alternative care programs, and spent less time in high cost inpatient and residential treatment. Please understand that alternate care was not used because it was less expensive but because with early intervention it was the most appropriate type of care. At the same time we believe that the care employees and their families received was better tailored to meet their needs, and more focused on assisting them in returning to productive functioning at work and school. Further, costs associated with increasing utilization of mental health services were offset by decreases in medical treatment cost. Other large employers who provide generous parity or near parity benefits in concert with introduction of care management have experienced similar cost reductions. [6]

Productivity Costs

Delta is also making a concerted effort to assess the impact that mental illness and addiction disorders have on employee productivity. We have found that depression and other mental illnesses account for more employee disability days than any of the other major causes of disability: diabetes, hypertension, back pain, and heart disease. [7] Our company's experience is entirely consistent with many studies of the impact of depression on productivity [8] For this reason, Delta has been actively involved in introducing depression awareness and education programs to encourage our employees and their families to seek appropriate treatment. Doing so is cost effective for our company. We have expanded our view of mental health and substance abuse treatment. As is the case with many other large employers [9], we are placing less emphasis on managing access to behavioral health care services and focusing more on employee education, early intervention mechanisms, disability prevention, and return-to-work programs.

Good data exists to support parity from a productivity perspective. The World Health Organization reports that in the major industrialized countries major depression accounts for 24 percent of the disability days in adults. [10] My colleagues in the EAP at Bank One have done a phenomenal job of documenting the tangible

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[5] U.S. Dept. of Health and Human Services, National Institute of Mental Health (1998) Parity in Financing Mental Health Services: Managed Care Effects on Cost, Quality and Access: An Interim Report to the Congress by the National Abuse Benefits,"U. S. Dept. of Health and Human Services, Substance Abuse and Mental He Advisory Mental Health Council; also, M. Sing, et al, (1998) The Costs and Effects of Parity for Mental Health and Substance Abuse, Mental Health and Substance Abuse Administration (1998)

[6] K. Apgar, (2000) Large Employer Experiences and Best Practices in Design, Administration, and Evaluation of Mental Health and Substance Abuse Benefits—A Look at Parity in Employer-Sponsored Health Benefit Programs, Washington Business Group on Health.

[7] The Report of the Surgeon General cites estimates that approximately 20% of the population experiences mental illness during any given year. Report of the Surgeon General (1999) 46.

[8] A. D. Lopez, in C. J. L. Murray (ed.) (1996) The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected. Harvard School of Public Health: Cambridge, MA.

[9] England (1999).

[10] World Health Organization, (1999) "The Double Burden: Emerging Epidemics and Persistent Problems, The World Health Report, Ch. 2, 16.

cost associated with depressive disorders. Their 1989–1992 disability study armed them with the financial data which motivated senior management to place high priority on health and wellness.[11] The EAP manages all mental health disability to ensure appropriate care is provided. Bank One represents an excellent example of one of the many fine corporate initiatives which exist to help employees achieve and maintain balanced, healthy lives. Where we lack sufficient study is on the value of the programs and services which encourage utilization and address stigma.

Continuing Issues

Understanding of the Impact of Mental and Addictive Disorders on the Workplace:

Our experience and the approaches that we use parallel those of similar large employers, including some of those who participated in making recommendations to OPM. We are convinced that provision of generous mental health and substance abuse benefits is cost effective. Nevertheless, we recognize that there is still work to be done to make the business case for adequate access to appropriate mental health and substance abuse care, It is difficult to associate specific cost avoidance or cost savings figures with the earlier return to full functioning evidenced in those who receive early and appropriate intervention. It is equally cumbersome to convince financial decision makers that real dollar savings are directly attributable to the provision of the programs and services which, in concert with comprehensive mental health benefits, make a difference in the health and productivity of employees. No one will argue against the premise that healthy employees are more likely to come to work and produce more. However, finance still wants to know exactly how much is saved.

Despite our experience and that of many comparable large employers, nearly half of all employers still have significant limits on inpatient and outpatient mental health treatment.[12] In addition, large employers like Delta have the capacity to manage and address the cost effectiveness of their behavioral health benefit programs that may not be true of smaller employers.

Stigma and the Need for Employee Education and Assistance Programs:

Perhaps even more important than cost concerns is the persistent and pervasive stigma against those with mental and addictive disorders. For Delta and other large employers like those identified above, the goal continues to be to encourage employees to get treatment early and to be sure that they will receive appropriate, comprehensive care when they access it. Indeed, under the Delta behavioral health benefit, we provide the first outpatient treatment visit free. We want to be sure that cost will not be a barrier to identifying problems and seeking resolution.

Nevertheless, despite very generous mental health as well as substance abuse benefits, the continuing stigma attached to mental and addictive disorders, and the fear of adverse consequences from seeking treatment, still discourages some of our employees from accessing available care. To address this issue, Delta has enhanced and expanded its EAP to focus on programs to help employees know when they might benefit from accessing treatment for themselves or their families, and to make sure that employees know how to access their benefits. Education about the impact of emotional and mental health issues on wellbeing is essential. For example, there are far too many individuals who did not understand that clinical depression is more than feeling sad and is in fact a treatable illness. The EAP plays a vital role in providing education for line employees as well as management. In addition, the accessibility of onsite EAP clinicians reinforces the Company's commitment to employees.

We also work toward eliminating stigma while addressing employees concerns about information sharing and confidentiality. Other large employers also place great emphasis on developing comprehensive programs for employee education and communication to encourage access to appropriate care and fight the stigma against seeking treatment.[13] As a result of the strengthening of the EAP, we at Delta have found that employee utilization of their mental health and substance abuse benefits have doubled. Some may view greater utilization as simply a cost increase; we regard it as a sign that we are reaching individuals who have a need for services. Our ability to identify and treat early is clearly associated with cost savings. As with medical care, the earlier the intervention the less impairment the individual experiences and the less expensive the required treatment. However, we recognize that the continuing stigma against seeking such treatment adversely affects the willing-

[11] A. R. McIlvaine, "Fighten the Blues," Human Resource Executive, May 2000 Special Issue, 46.

[12] Kaiser Family Foundation and Health Research and Education Trust (11999) Employer Health Benefits, 1999 Annual Survey, 94-96.

[13] Apgar (2000)

ness of some individuals too seek care. Our ongoing efforts include consistent education about the importance of health, physical and mental, and the productivity results which can be achieved by healthy employees. This is an issue we all must continue to address on a corporate as well as national level for it is not Delta employees who are wary of mental illness stigma but our nation. [14]

Quality of Care:

While parity laws focus on reducing benefit plan barriers to access to mental health and substance abuse treatment, they do not address quality of care. Similarly, although managed care has been an essential tool to assuring that employers are able to afford to provide for more generous access to mental health and substance abuse treatment, there is still widespread concern that managed behavioral health has not assured sufficient access or quality of care. Appropriate behavioral health care must be timely, it must be tailored to the individual needs of the consumer, and it must offer a continuum of services through access to high quality provider networks.

These expectations require improvements in the care delivery system that will take time and cannot happen over night. Like other large employers, we at Delta are still struggling with the limits on availability and access to performance information that can tell us whether the care we are purchasing in fact is providing quality care for our employees and their families. And we are in a much better position to address this issue than smaller employers.

We want to be sure that we are purchasing health care from a consumer centered, performance-based system, where behavioral health is well integrated into the overall system of care. And we need to be able to quantify the value of our investment in our employees' health and well being. While we look at access measures and utilization of treatment, we recognize that there is still far to go before we can be certain that the care we are purchasing provides quality services to our employees. The EAP is charged with monitoring our delivery of services and implementing recommendations designed to ensure the best possible product for our employees. Their oversight provides the essential focus on quality care vs. cost savings.

C. Conclusion

In summary, Delta is a strong advocate of the goal of expanding employee access to high quality behavioral health services. We believe early, appropriate treatment of mental and addictive disorders is essential to productivity in the workplace, is cost effective, and is vital to our employees and their families. However, we are not confident that the complicated factors involved in providing and managing high quality employer-sponsored behavioral health care are amenable to solution through legislative mandates.

The CHAIRMAN. Mr. Rosen.

Mr. ROSEN. Thank you, Mr. Chairman and Senator Wellstone.

Mental illness, as we have heard today, takes a tremendous toll on our society, and when our loved ones are sick, we all want the best and the highest-quality treatment available. However, I think it is important that we have a better understanding of the consequences of mandates generally and of this mandate in particular, both intended and unintended.

Employers and insurers have made really great strides, as Delta attests to, over the last decade in terms of treating mental illnesses. Over 90 percent of employers provide some coverage for mental health, and managed care is offering expanded coverage and better-quality coverage. And major breakthroughs in pharmaceuticals have greatly improved treatment for mental illness during the past decade. A growing majority of employers like Delta are addressing workers' mental health outside the concept of traditional benefit plans, through things like employee assistance programs.

Yet both public programs and private sector programs struggle to manage the costs of mental health benefits. The science of diagnosing and treating mental disorders still lags behind the science of dealing with physical disorders. This is changing, and we are learning much, much more about the causes of mental illness, par-

[14] The Report of the Surgeon General, 8-9.

ticularly for some of the more serious mental disorders; but nonetheless we know much less than we need to, and this uncertainty makes it much more difficult for employers and insurers to manage costs.

There are many, many different studies on the costs of mental health parity legislation. We have heard numbers today from earlier panels and from this panel. The analyses use different approaches, as one would expect, but there are a couple of key facts that cut across all the studies no matter who pays for them and no matter where they are done. Here they are.

One, we can quibble about the exact amount, but it is clear that mandated parity in whatever form has a cost. Second, the more comprehensive the parity requirement, the more significant the cost. Third, we have talked a little bit today about average cost estimates and the average cost of mandates, but in reality, very few employers, very few consumers, are at the average. Talking about averages really ignores the fact that some consumers are hit much harder by mandates than others. Typically, these consumers are the ones who are least able to deal with these increased costs.

For example, parity legislation has the most significant impact on consumers, as we have heard, who do not choose tightly managed care through HMOs. This means that those who work for smaller companies—traditionally, there is less managed care at smaller companies—and consumers in rural areas without access to extensive managed provider networks are likely to experience higher costs.

In fact, studies by proponents of mental health mandates indicate that the cost of full parity is more than twice as much in a PPO setting or in the point-of-service setting and more than three times as much as in a fee-for-service setting as it would be under an HMO.

Advocates of mental health parity rely on the fact that there is managed care to support claims that mandate coverage is actually going to have very little cost or even save costs. But many of the proponents of mental health parity legislation also support legislation that would cripple some of the most important tools of managed care. This is a very important point, because mental health parity legislation that we are talking about today is really not considered in a vacuum. We are also debating in this Congress patient protection legislation. The House is scheduled to vote next week on antitrust waiver legislation for physicians and health care providers, and those laws could significantly weaken the managed behavioral health and the managed health care techniques that are used to help control some of these costs and hopefully improve quality, and they can substantially magnify the impact and the cost impact of a parity mandate.

The fact is that somebody has to pay for the cost of increased coverage. It simply does not come free. And while Congress has only recently begun to impose a health coverage mandate on the private sector, really beginning in 1996, the States have been at it for years, and these costs have added up. The number of State mandates has increased 25-fold over the last two decades, and it has made health insurance disproportionately more expensive for

small employers and causes as many as one in four Americans, according to several studies, to lose their health insurance altogether.

Today, 44 million Americans—and the number is growing—have absolutely no access to any kind of health insurance coverage whatsoever despite the record economic times that we live in. HIAA believes that our first priority should be expanding basic coverage to those Americans who do not have it.

We share this committee's concerns about the impact of mental illness and the impact it has on our patients, their families, and our society, but we continue to believe that benefit coverage decisions should be made by consumers and employers, those who are paying the premiums. We oppose mandates such as mental health parity that will drive up the cost of coverage and, we believe, lead to more uninsured. Instead, we think that expanding coverage should be job one and should be the primary focus.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Rosen follows:]

PREPARED STATEMENT OF DEAN ROSEN

Mr. Chairman and members of the committee, I am Dean Rosen, senior vice president of policy and general counsel for the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. HIAA also is the nation's premier provider of self-study courses on health insurance and managed care.

Before joining HIAA, I worked for several years as a congressional staff member, including as health counsel for the former chair of this committee, Senator Nancy Landon Kassebaum.

I am honored to have the opportunity to address the committee today on the issue of mental health parity in health coverage.

Federal Mental Health Parity Legislation

The Mental Health Parity Act of 1996, which prohibits employers from imposing annual or lifetime dollar limits on mental health coverage that are more restrictive than those imposed on medical and surgical coverage, is scheduled to sunset in September of next year. Some have criticized the act as not going far enough to equalize mental and physical benefits.

Senators Domenici (R-NM) and Wellstone (D-MN) have introduced new legislation, the Mental Health Equitable Treatment Act of 1999 (S. 796), which would go significantly further. It would prohibit employer-sponsored health plans from imposing limits on the number of covered inpatient days or outpatient visits for mental health conditions unless the same limits are imposed on medical and surgical benefits. In addition, no limitations whatsoever would be allowed on "severe biologically-based mental illnesses" unless the same limitations are imposed on medical and surgical benefits (roughly half the states that have enacted parity legislation have covered only serious or "biologically-based" mental illnesses[1]). Employers with 25 or fewer employees would be exempted from the requirements of the legislation.

The issue of parity for mental health coverage raises a host of complex issues. Some believe coverage for treatment of mental illness should be equal with other areas of coverage. On the other hand, added coverage almost always increases costs. One thing is clear: Mental illness takes a tremendous toll on our society. According to the Surgeon General's recent report on mental health, one out of every five Amer-

[1] Merrile Sing et al., The Costs and Effects of Parity for Mental Health and Substance Abuse Benefits, U.S. Department of Health and Human Services, Public Health Service, March 1998, p. 5.

icans suffers from some form of mental disorder,[2] with direct and indirect costs to society totaling nearly $200 billion a year.[3]

As we seek ways to ensure that the needs of those with mental illness are met, there are a number of difficult public policy issues that must be confronted. One of these is the difficulty that health care payers sometimes have in effectively administering mental health benefits. Related to this is the cost associated with expanded benefit levels. Increases in the cost of health insurance, whatever the source, make coverage less affordable and contribute to the growing number of Americans who lack coverage. In fact, it was in the context of the 1996 legislative debate on mental health parity that the Congressional Budget Office estimated that a 1 percent increase in premiums would increase the number of uninsured Americans by 200,000. Since then, a number of private economists have estimated that at least 300,000 Americans lose their health coverage each time a mandate increases costs by 1 percent.

Vermont Governor Howard Dean underscored the link between coverage mandates, costs, and the number of people who lack health insurance in this year's State of the State address, noting that "state-passed mandates have contributed about 25 percent of this year's increase in insurance premiums. Many of these I have supported. But this year I ask the Legislature not to pass any additional mandates. . . . We cannot vote on the one hand to expand insurance coverage and increase the cost of liability insurance, and then go out in an election year and point the finger elsewhere for the increase in insurance costs."[4]

As Governor Dean points out, increases in the cost of insurance matter. Ultimately, increased costs are not borne by health insurers - they fall on employees and individual consumers. There is a balance that must be achieved between benefit mandates and the cost of insurance - where that balance is struck will have an impact on how many Americans have health coverage, and how many do not.

Treatment Options Raise a Host of Complex Issues

Coverage of mental health services presents some unique challenges. As the Surgeon General's report recognizes, "mental health" itself is difficult to define—what it means is subject to different interpretations that are value- and culture-based.[5] As a result, our current conceptions of mental illness incorporate a wide variety of conditions of varying significance.[6] While some severe mental disorders can be diagnosed as reliably as most medical conditions, for a substantial number of other diagnostic categories there is little research evidence.[7] That is why it is important to consider not only the level of coverage required by mental health parity mandate legislation, but also which conditions are required to be covered. As we will see, the costs associated with "severe biologically-based mental illnesses" can be better managed than those associated with many other mental disorders or with alcoholism and substance abuse.

Roughly one out of every five children and adolescents suffers from a diagnosable mental illness or addiction each year, but only 11 percent experience a significant functional impairment.[8] Overall, one in five Americans has a mental disorder in any given year.[9] (Fifteen percent of adults and 21 percent of children between the ages of nine and 17 receive mental health services each year.)[10]

For most mental illnesses there is a range of different treatment approaches that may be used, including various forms of psychosocial therapy and, in many cases, pharmacological treatment.[11] Unfortunately, for a variety of reasons, treatments that work well in clinical trials can be much less effective in real-world settings.[12] Moreover, there has been little research comparing the relative merits of the different treatments available for the various mental disorders, and some studies sug-

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[2] Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, Substance Abuse and Mental Heath Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999, p. 46.

[3] Mental Health: A Report of the Surgeon General, p. 411, 412.

[4] Howard Dean, 2000 State of the State Address, January 4, 2000.

[5] Mental Health: A Report of the Surgeon General, p. 5.

[6] For a discussion of the how conditions come to be included in the Diagnostic and Statistical Manual of Mental Disorders (D.S.M.) see Joe Sharkey, "It's a Mad, Mad, Mad, Mad World: You're Not Bad, You're Sick. It's in the Book," New York Times, September 28, 1997, Section 4, page 1.

[7] Grayson Norquist and Steven E. Hyman, "Advances in Understanding and Treating Mental Illness: Implications for Policy," Health Affairs, September/October 1999, p. 35.

[8] Mental Health: A Report of the Surgeon General, p. 124.

[9] Mental Health: A Report of the Surgeon General, p. 20.

[10] Mental Health: A Report of the Surgeon General, p. 408, 409.

[11] Mental Health: A Report of the Surgeon General, p. 65.

[12] Mental Health: A Report of the Surgeon General, p. 72.

gest that the characteristics of the therapist may affect outcomes more than the specific treatment used.[13] (This is particularly an issue with children.)[14]

The challenges presented by misdiagnosis are well illustrated by the recent concern that psychotropic medications such as Ritalin may be over-prescribed for many children.[15] It now appears that in many cases treatment was, in fact, inappropriate. This is a clear example of how difficult it can be to diagnose certain mental disorders, and to determine both when treatment is appropriate and what treatment is appropriate.

Because different courses of treatment may have significantly different costs, this uncertainty complicates the management of mental health costs. For instance, a recent study identified five major treatment categories for schizophrenia. Considering just pharmacotherapy, costs vary significantly, with the cost of newer drugs being roughly 100 times that of older, generic ones.[16] In one study of acute-phase depression, researchers found that 20 to 26 percent of the spending was on treatments that were unlikely to provide meaningful benefits.[17] For all treatments, the average incremental cost per depression-free case was $6,031. But for treatment with selective serotonin reuptake inhibitors (SSRIs) alone, the incremental cost per depression-free case was only $2,351.[18]

The Costs of Mandated Mental Health Parity

Uncertainty regarding the diagnosis of many mental disorders and the appropriateness and effectiveness of the various treatment options that are available can make the cost of mental health benefits very difficult to manage. There have been many different studies of the cost of mandated mental health parity. While the approaches used by these analyses vary, some common conclusions may be drawn from a survey of these studies.

First, while the studies may disagree over the exact level of cost, it is clear that there is a cost associated with parity. The level of cost varies dramatically based on the type of health coverage a person has. The lowest costs are associated with tightly managed health maintenance organization (HMO) coverage. However, the cost impact of mandated mental health parity coverage is felt much more acutely by consumers with coverage through health plans using point of service (POS) and preferred provider organization (PPO) arrangements, and the highest costs typically are associated with indemnity coverage. For instance, one study estimated that mental health parity would raise the average family premium for HMO coverage by only 0.6 percent, but also found that the impact on POS coverage would be 3.4 percent, and that the impact on PPO and indemnity coverage would be 4.8 percent.[19]

It is also important to note that those studies that have claimed that mandated parity has no cost, or results in cost savings, have looked at employer-sponsored plans or other health benefit programs that adopted managed care at the same time they incorporated mental health parity in their benefits. In those cases, the savings resulting from the adoption of managed care masked the cost of expanded coverage for mental illness.[20]

It is also extremely important to note that current discussions about mandated coverage are not taking place in a vacuum. While proponents of mental health parity mandates must rely on the widespread adoption of managed care (in particular, tightly managed HMO coverage) to hold down the cost impact of the mandate, they often ignore the fact that legislation being considered simultaneously would banish the very tools insurers and employers must rely on to effectively manage these costs. (Even more ironic is the fact that some are proponents of both types of legislation.) For instance, the Senate version of the Patients' Bill of Rights legislation

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[13] Issues in Mental Health Care Benefits: The Costs of Mental Health Parity, EBRI Issue Brief Number 182, Employee Benefit Research Institute, February 1997, p. 13. John Morgan, "Why Freud Isn't Dead," Scientific American, December 1996.

[14] Mental Health: A Report of the Surgeon General, p. 140.

[15] Julie Magno Zito et al., "Trends in the Prescribing of Psychotropic Medications to Preschoolers," Journal of the American Medical Association, February 23, 2000, p. 1025. "Psychiatric drugs soaring among toddlers," USA Today, February 22, 2000. Al Neuharth, "Drugging unruly kids lazy parents' cop-out," USA Today, December 17, 1999.

[16] Anthony F. Lehman, "Quality of Care in Mental Health: The Case of Schizophrenia," Health Affairs, September/October 1999, p. 55.

[17] Richard G. Frank et al., "The Value of Mental Health Care at the System Level: The Case of Treating Depression," Health Affairs, September/October 1999, p. 85.

[18] "The Value of Mental Health Care at the System Level: The Case of Treating Depression," p. 82, 85.

[19] The Costs and Effects of Parity for Mental Health and Substance Abuse, p. 32.

[20] 20 For a graphic illustration of this offset effect, see Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality, U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, May 1998, p. 18.

would require employers to offer a POS option to all employees. Yet as noted above, the cost of parity is significantly higher with POS coverage than with HMO coverage.

Perhaps the one issue in the "patient protection" debate with the greatest potential adverse impact is that of health plan liability. The negative cost effects of "defensive medicine" are recognized and well documented. For example, in states with weak or no limits on malpractice liability, spending on treatment of heart attacks alone rose 25 percent faster than in states with meaningful limits-with no appreciable effect on health outcomes.[21] Several studies have estimated the costs associated with defensive medicine. One study by the Office of Technology Assessment found that up to 8 percent of diagnostic procedures were undertaken because of liability concerns.[22] Another study focusing on Medicare beneficiaries found a 5 to 9 percent reduction in services resulted from reducing provider liability pressures.[23] An examination of the combined costs of liability premiums and defensive medicine practices found such costs amounted to 5 percent of total costs for an Indiana hospital.[24] Even a limited number of lawsuits over wrongful death or denial of care could lead plan administrators to authorize unnecessary care-despite a lack of objective medical information supporting such care-in order to avoid potential lawsuits.[25] Because of the relative lack of information on the most appropriate and effective treatments for many mental disorders, this area is particularly vulnerable to defensive over-treatment.

It is not only the so-called "patient protection" proposals that have the potential to undermine managed care's ability to control costs. The Quality Health-Care Coalition Act of 1999 (H.R. 1304), expected to be considered by the House of Representatives later this month would, by waiving antitrust restrictions, allow physicians and other health care providers to collude and demand higher reimbursement. It also would reduce or eliminate utilization management crippling the ability of health plans to control costs. By increasing the prices paid for health care and weakening public and private health plans' ability to manage costs, over the long run this legislation alone could increase the cost of private health insurance by 10 to 13 percent.[26] it almost certainly would magnify considerably the impact of any mental health parity mandate.

While much of the work on the cost of parity focuses on average cost levels, it is important to consider the impact on specific populations. For instance, managed mental health networks are not widely available, or even practical, in many rural areas.[27] Further, the cost impact of mental health parity legislation clearly will be more significant for small employers. But small employers are significantly less likely to offer health benefits than are other firms, and their employees are more likely than other workers to be uninsured.[28] Moreover, workers in small firms are less likely to be covered by HMOs.[29] Thus, the costs of parity are likely to fall hardest on those who are most vulnerable to the loss of coverage.

Not surprisingly, parity laws have been shown to result in increased use of managed care and tighter utilization management of mental health care services.[30] HMO coverage is a good choice for many consumers. However, both public opinion surveys and market penetration data suggest that most Americans are not willing to embrace HMO coverage as their only option. Consumers are increasingly turning from tightly managed HMOs to PPOs, POS plans, and other delivery system models characterized by increased choice and flexibility. HMO market share has declined from 31 percent in 1996 to 28 percent in 1999, whereas PPO market share has in-

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[21] Kessler, D.P. and M. McClellan, "Do Doctors Practice Defensive Medicine?" The Quarterly Journal of Economics, Feb. 1996.

[22] U.S. Office of Technology Assessment, Defensive Medicine and Medical Malpractice, July 1994

[23] "Do Doctors Practice Defensive Medicine?"

[24] Macintosh and Murray, "The High Cost of Medical Liability," Hudson institute Briefing Papers, Hudson Institute, April 1994.

[25] Gresenz, et al., A Flood of litigation? RAND, July 1999.

[26] Charles River Associates Inc., The National Costs of Physician Antitrust Waivers, HIAA, March 2000.

[27] Rural Neglect: Medicare HMOs Ignore Rural Communities, Families USA Publication No. 99-15, Families USA Foundation, September 1999. R.T. Sliffin, et.al., "Medicaid Managed Care Programs In Rural Areas: A Fifty-State Overview," Health Affairs, November/December 1998.

[28] William S. Custer, Health Insurance Coverage and the Uninsured, Health Insurance Association of America, January 1999.

[29] Employer Health Benefits: 1999 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust, 1999, p 56.

[30] The Costs and Effects of Parity for Mental Health and Substance Abuse Benefits, p. 15.

creased from 28 percent to 38 percent and POS market share has increased from 14 percent to 25 percent.[31]

The Public Sector Has a Difficult Time Managing Mental Health Benefits As Well

Managing the cost of mental health coverage is not a concern unique to the private sector. Public sector programs have found this to be challenging as well. There are a number of significant examples of the difficulties the Medicare and Medicaid programs have had in controlling benefits for mental health care. Some cases represent outright fraud. Of course, these instances do not imply that all, or even most, providers of mental health services act improperly. But they do illustrate the difficulty payers have in managing these benefits.

One example is the Medicare program's experience with coverage for partial hospitalization services. Congress in 1990 expanded Medicare's partial hospitalization benefit, which provides for intensive psychiatric treatment to be provided on an outpatient basis by allowing community mental health centers (CMHCs) to provide partial hospitalization services to Medicare beneficiaries. (Prior to that time, Medicare only reimbursed for partial hospitalization services if they were provided in a hospital outpatient department.) The number of centers has grown rapidly since Congress passed the law. Since then, the Health Care Financing Administration (HCFA) and the Inspector General of the Department of Health and Human Services (HHS) have identified significant waste, fraud, and abuse in the partial hospitalization benefit administered by CMHCs.[32]

- Between 1993 and 1996 payments to these centers rose significantly - total payments by 342 percent, per capita payments by 319 percent, with average payment per beneficiary exceeding $ 10,000.
- A review of 18 Florida CMHCs concluded that 17 did not provide necessary core services; 89 percent of beneficiaries were not eligible for services; and 100 percent of the services provided were not covered. Payments were suspended to all 18 centers and 15 centers have since been terminated from the Medicare program.

Numerous other instances of waste and fraud have been documented in the mental health area.[33]

One estimate put the overall price tag for mental health-related fraud (public and private programs) at $42 billion a year.[34] The same source concluded that:

"Psychiatrists make up 8 percent of doctors, but 18 percent of those health care practitioners that have been kicked out of the Medicare system for fraud. Last year, [$]411 million was paid to the government in fines and penalties for health care fraud and, 90 percent of that was paid by psychiatrists or psychiatric institutions."

Administration of benefits is not the only challenge public programs face. It is clear that public payers also recognize the importance of balancing cost and coverage is clearly recognized. For instance, new Medicare guidelines have just been announced to more directly recognize the importance of cost when deciding what items and services will be covered by the program.[35] In contrast to the long-standing rule that care would qualify for coverage if it was "reasonable and necessary," the new rule requires clinical evidence of effectiveness and "added value" over alternatives that are already covered. This policy change illustrates that public health

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[31] Employer Health Benefits: 1999 Annual Survey.

[32] "Fact Sheet, Protecting Medicare's Partial Hospitalization Benefit in Community Mental Health Centers," HCFA, October 5, 1998. In September of 1998 HCFA announced a 10-point program intended to address these problems. This program included: terminating the worst offenders, intensified medical review, and the implementation of a prospective payment system.

[33] In February 1999, Nova Southeastern University agreed to pay the state of Florida $4.2 million to settle claims of improper billing and the provision of questionable mental health care services to Medicare and Medicaid beneficiaries. Shortly before that, Integra, a Pennsylvania-based provider of outpatient mental health services, agreed to pay $3 million to settle charges that it had billed Medicare for unnecessary individual and group therapy provided to nursing home residents. In November of 1998 an Indiana businessman was indicted by a federal grand jury for receiving $900,000 in kickbacks from two Florida psychiatric hospitals in return for patient referrals. A similar but unrelated indictment was brought against two other businessmen, one from Texas and one from Georgia. In February of this year, Charter Behavioral Health agreed to pay $600,000 to settle Medicare and Medicaid fraud charges involving claims for psychiatric services. Just last month, an Illinois psychiatrist and his office manager were indicted on 15 counts including mail fraud, health care fraud, false claims, and conspiracy. They allegedly submitted claims to Medicare, Medicaid, and private health plans for services that were never provided and for services provided by unqualified personnel. Also last month, a psychologist in Birmingham, Michigan, was charged with fraudulently billing Blue Cross and Blue Shield of Michigan.

[34] "The Hidden Side of Psychiatry: Part I of a 2-Part Series," Alt Health Watch, Townsend Letter for Doctors and Patients, January 1997.

[35] BNA Daily Report for Executives, May 12, 2000, p. A-133.

insurance programs are no more immune to cost pressures than are private programs.

Costs of Mental Health Parity Mandates Would be Borne by Consumers and Employers

Health insurers act as financial intermediaries. The costs of the benefits we provide are passed on to our customers in premiums. Ideally, health insurers would like to sell as much coverage as possible. However, the benefits provided by insurers are determined by the demands of the markets we serve and the prices that our customers are willing and able to pay.

Employers have made a significant commitment toward addressing the mental health needs of their employees. Some level of coverage for inpatient and outpatient mental health care is provided to over 90 percent of the employees participating in employer-sponsored health plans.[36] The past 10 years have also seen the introduction of many new pharmaceutical treatments for mental disorders.[37] At the same time these innovative new drugs have become available, private prescription drug coverage, which makes no distinction between mental and physical disorders, has grown dramatically.[38] In addition, a growing majority of employer-sponsored plans are addressing workers' mental health needs outside of the traditional health benefit plan, through innovative approaches such as Employee Assistance Programs (EAPs).[39] Many, however, do find it necessary to take some action to limit the cost of mental health coverage.

The cost of health coverage is not just a parochial concern of employers, but is perhaps the primary health policy challenge facing the nation. Roughly 44 million Americans lack any health insurance coverage. The primary reason so many are uninsured is the high cost of health care and health care coverage.[40] In fact, research shows that the decline in employer-sponsored health insurance coverage over the period from 1979 to 1995 can be attributed almost entirely to the increase in health care spending relative to personal income.[41] One out of five uninsured Americans is offered health coverage by an employer but declines it—when asked why, two thirds of them cite the CoSt.[42]

In May of 1998, the HIAA Board of Directors formally adopted a policy (InsureUSA) for dealing with the problem of the millions of Americans who lack health insurance coverage. Since that time, HIAA has aggressively promoted the proposal, because HIAA believes the uninsured are the most significant long-term threat to the American health care system. Two central themes of the InsureUSA proposal are a firm commitment to private health insurance markets and a recognition of the need to help low-income Americans gain access to coverage.

Because uninsured Americans are not all identical, there is no single solution for them all. InsureUSA recognizes that there is a role for both the public and private sectors and for both employer-sponsored and individually purchased health insurance. However, the high cost of coverage is a constantly recurring problem that must be addressed if we are to make meaningful headway in providing health care coverage to more Americans.

As the number of Americans unable to afford health insurance has risen, the number of specific benefit mandates has also skyrocketed, adding significantly to the cost of coverage. The number of state mandates has increased 25-fold during the last two decades, making health insurance disproportionately more expensive for small companies and causing as many as one in four Americans to be uninsured.[43] For example, mandates account for 21 percent of health insurance claims in Virginia, 11 to 22 percent of claims in Maryland, and 13 percent of claims costs in Massachusetts.[44]

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[36] Paul Fronstin, et al., EBRI Databook on Employee Benefits, 4th edition, Employee Benefit Research Institute, 1997.

[37] Mental Health: A Report of the Surgeon General, p. 68.

[38] Mental Health: A Report of the Surgeon General, p. 417.

[39] Issues in Mental Health Care Benefits: The Costs of Mental Health Parity, EBRI Issue Brief Number 182, Employee Benefit Research Institute, February 1997, p. 7.

[40] Health Insurance Coverage and the Uninsured: 1990-1998.

[41] Richard Kronick and Todd Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979-1995," Health Affairs, March/April 1999, p. 30.

[42] Kenneth E. Thorpe and Curtis S. Florence, "Why are Workers Uninsured? Employer-Sponsored Health Insurance in 1997," Health Affairs, March/April 1999, p. 213. Peter J. Cunningham et al., Who Declines Employer-Sponsored Health Insurance and is Uninsured?, Center for Studying Health System Change, Issue Brief Number 22, October 1999. The Surgeon General's report estimates that 75 percent of the uninsured are in employed families that cannot afford to purchase health insurance. Mental Health: A Report of the Surgeon General, p. 419.

[43] Gail A. Jensen and Michael A. Morrisey, Mandated Benefit Laws and Employer-Sponsored Health Insurance, Health Insurance Association of America, January 1999.

[44] Jensen and Morrisey, Mandated Benefit Laws and Employer-Sponsored Health Insurance.

At least one in five (and perhaps as many as one out of every four) uninsured Americans lacks coverage as a result of the cost of these mandates.[45] As employers try to keep their health plans affordable, they must carefully consider which benefits are most valuable to their employees and their families. Survey research indicates that while most Americans support coverage for mental disorders, that support decreases when they realize that it will result in higher premiums, and that they generally consider coverage for physical disorders more important than coverage for mental disorders.[46] In addition, there is greater public support for the coverage of such severe mental disorders as schizophrenia than there is for coverage of other conditions.[47] These priorities are naturally reflected in the decisions they and their employers make when purchasing health insurance.

While there is disagreement around the level of cost associated with parity, it is clear that there is a cost and that this increased cost will put health insurance out of reach for some Americans. Recently, Dr. William Custer of Georgia State University performed a study for HIAA that looked at the impact that state health insurance laws and regulations have on coverage levels. The one benefit mandate that he included in the study was mandated mental health coverage. This study was unique in that it directly measured the impact on the number of people who have health insurance coverage. Dr. Custer found that in states that mandate coverage for mental illness, the likelihood that a given citizen will be uninsured increases by 6 percent.[48] Similarly, estimates of the impact of the number of Americans who would lose health insurance coverage as the result of a full federal parity requirement range from 800,000 to 3.2 million.[49] The high-end estimate represents more than three times the number of Americans who lose coverage each year due to all other causes, and even the low-end estimate would double the number of Americans who lose coverage.[50]

Conclusion

There is a perception that private health care plans have unlimited dollars for coverage, and therefore, expansions of benefit plans are an acceptable way to bring more services to insured persons. We must understand that not everyone has the high level of employer contributions that federal employees enjoy, nor do businesses have unlimited dollars for the health benefits programs that they voluntarily offer to their employees. Nor do consumers have unlimited dollars for health care coverage given other competing demands. Each group, no matter how well intended, that advances one level of benefits may fail to see the effects of its advocacy for extended coverage as it relates to the efforts of other groups. While we can argue over the merits of individual mandates, the fact is, the cumulative impact can be devastating, particularly for those Americans who are most vulnerable to cost increases.

And let me add one additional note on the issue of mandated benefits. All too often when a mandated benefit is proposed, the benefit mandated can become far more extensive in scope than originally intended. Take the current discussions in both houses of Congress on the issue of emergency room services. The original intent of many legislative proposals was to guarantee insured persons the right to payment for their emergency care services if their condition, or their perception of their condition, warranted a trip to an emergency facility. Now, however, when we talk about mandates on emergency care, we include payments for post-stabilization services as well as maintenance. All too often legislative proposals dictate not only the benefit required but the terms of the service, how it must be provided, whether it can be exempt from any utilization review or plan oversight, and so on. As the scope of the mandate itself expands, so does its costs.

Mr. Chairman, HIAA's members share the concerns of this committee about the impact that mental illnesses have on patients, their families, their employers, and our society. However, we must also recognize that extending full parity in this area will drive up the costs of coverage, and increase the number of uninsured Americans. Instead, we believe that we must work together to expand health coverage to as many consumers as possible.

Again, thank you for the opportunity to testify today. I am happy to answer any questions you may have. Thank you.

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[45] Mandated Benefit Laws and Employer-Sponsored Health Insurance.

[46] Mental Health: A Report of the Surgeon General, p. 8.

[47] Mental Health: A Report of the Surgeon General, p. 8.

[48] William S. Custer, Health Insurance Coverage and the Uninsured, Health Insurance Association of America, January 1999, p. 14.

[49] Issues in Mental Health Care Benefits: The Costs of Mental Health Parity, p. 11.

[50] There were 43.1 million uninsured non-elderly Americans in 1997. By 1998 this number had grown to 43.9 million, an increase of 800,000. Health Insurance Coverage and the Uninsured, p. 3. Health Insurance Coverage and the Uninsured: 1990-1998, p. 1.

The CHAIRMAN. If Congress were to expand upon the existing mental health parity law, what would you consider the most reasonable approach, and what should we do?

Dr. Libertoff.

Mr. LIBERTOFF. I think we started with the premise in Vermont, where we dealt with that question by saying let us be reasonable, let us expect the impossible. So there is no question that moving to a comprehensive approach is a significant step which must be taken. But I would highly recommend that there be consideration given to two or three very important elements.

One is the cost factor. As stated, I think that an argument can be not only made but successfully made that will show that in the partial parity approaches, you are building in most of your cost of increasing your behavioral health care coverage. In some ways, we think that is inappropriate and foolish. I think that that has to be reviewed very, very carefully.

I also think that it is time for all of us to deal with the issue of discrimination and stigma. Why is it that when it comes to parity for mental health, suddenly, we become overly concerned, in my opinion, that the cost may rise some, when we do not necessarily have that same argument when physical health has, happily and I think fortunately, been expanded?

I think that some of the same positioning occurred in our legislature in 1997, and I remember testifying following some very, very considered and in some ways very critical testimony from our business interests and our insurance interests, and I had to say that mental health parity began to be blamed for almost everything. The following day, there was a snowstorm, and I was sure that those lobbyists would come in and say it is because of this mental health parity bill that we now have a snowstorm in Vermont.

We can, we should, we must move more comprehensively to make this successful.

The CHAIRMAN. Thank you.

Dr. Duckworth.

Dr. DUCKWORTH. I think the Vermont legislation is completely laudatory and remarkable, and it may reflect more my personality style, which is that I think the perfect is the enemy of the good at times. So if I thought the Senate could realistically get the Vermont bill, I think it would be wonderful.

However, the idea that there is gross discrimination against all these catastrophic psychiatric illnesses which the Federal Government is hoping to make significant progress toward, in my opinion, that is quite substantial and is very noteworthy. I do not know if it is possible in this particular context to ask for more, but I certainly feel that Vermont is probably an ideal that we can all work toward. The question is what is the best way to get there.

I feel that the work that we are discussing now is a very substantial step which I think releases a lot of people from the second-class status that they currently do not enjoy.

The CHAIRMAN. Ms. Wooldridge, what evidence of the benefits of mental health services would you urge other companies to examine in developing their own plans?

Ms. WOOLDRIDGE. I would encourage looking at the total cost of care, not just in terms of what it costs to provide insurance coverage but what it costs if you do not have adequate treatment.

I would encourage companies to look at disability cost, productivity. For us in the airline industry, as you can imagine, safety is our primary concern. Having impaired employees is not an option for us. We have to be concerned about safety issues. So it is imperative that we recognize early, that we provide appropriate interventions, and that it is comprehensive care. But not only do we provide the facility-based care that is important, but also the aftercare. We need to prevent relapse. We need to keep people healthy.

So I encourage everyone to just look at the total cost of the picture and decide what is most appropriate for their employees.

The CHAIRMAN. Could you give the historical genesis of how you got to parity—what happened, when?

Ms. WOOLDRIDGE. I am not sure I can do it in 2 minutes or less. I will say that for a very long time, we had rich benefits that we spent a lot of money on, and as we began to look at managed care coming into play, what we recognized was that if we had some management, we might in fact be able to provide more appropriate kinds of care. So it is not just how much are we spending, but how appropriate is the care that we are providing.

When we made the switch to managed care, I had a psychiatrist call and say, "You are harming my client. I have been treating her five times a week for 15 years." That, unfortunately, is the kind of abuse you have when you do not have management.

So clearly there needs to be some management to make sure that the care is appropriate, that it is timely, and that there are no barriers to access.

The CHAIRMAN. Thank you.

Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

First let me thank all of you for being here. Dr. Duckworth, I would like to have you as a teacher—and thank you for coming on your birthday.

I want to make one point and ask one question. I think this is what Dr. Duckworth was saying, and maybe I will ask you to respond. The bill, Mr. Chairman, that Senator Domenici and I have worked on, following up on 1996, provides full parity for schizophrenia, bipolar, major depression, obsessive-compulsive, severe panic disorder, posttraumatic stress disorder, autism, and other severe and disabling mental illnesses such as anorexia and attention deficit hyperactivity disorder. It also provides full parity, regardless of category or designation of illness, when it comes to days in hospital and physician visits.

Mr. Chairman, just for the record, I am taking a look at the Senate and the House right now and what can pass, and I view this, Dr. Duckworth, as a significant step forward—would you agree with me—albeit not perfect. You know how we sometimes say do not make the perfect the enemy of the good.

If you were to accept my judgment that this is probably politically the very best we could pass right now, would this be a step forward, Dr. Duckworth?

Dr. DUCKWORTH. Yes. [Laughter.]

Senator WELLSTONE. And Dr. Libertoff?

Mr. LIBERTOFF. It would be a step sideways.

Senator WELLSTONE. OK. So if we could provide this coverage for many people who receive none of it right now, affecting many people because we cannot make it 100 percent perfect, it is a step sideways.

I would just suggest to you that all those people who go without coverage might not accept that view.

Mr. Rosen, I want to ask you how you respond to the point that has been made over and over again today about the discrimination—Dr. Duckworth's example of his own experience with treatment for cancer versus how other people are treated who struggle with mental illness who receive no coverage at all or receive very little coverage; the evidence in the GAO report of companies not even complying with the very modest bill passed in 1996, and then all the ways in which copays and deductibles are higher, and limitations on treatment in the hospital.

If we say to someone who has cancer, We will not treat you unless you have a proven treatment, and it has to be a certain kind of cancer before we will treat you—we do not do that—why should we do that with someone who is struggling with a mental illness?

Mr. ROSEN. Well, I think there is some truth to the fact that there has been a stigma traditionally associated with mental illnesses and their treatment. In looking at the medical literature, I think it is also a fact that we are making tremendous progress in being able to diagnose and treat mental illness, particularly severe mental illness.

I do not view it so much as discrimination as employers and others who are paying for the care and individual consumers choosing it, trying to better understand what they can accord to have covered. Employers like Delta I think are leading the way and showing that it can be done affordable, but as I said, I think it is a real concern that not everyone is in a position to manage the care in the way that Delta and other larger employers do and to control those kinds of costs. I think it is that fear of the potential cost impact and the impact it will have overall on the availability of benefits that leads to some of the differences in terms of types of coverage.

Senator WELLSTONE. But first of all, for the record, Dr. Hyman, looking at the different States' efforts, talked about a 1.4 percent increase—and we are going to see that report; we have heard about all the costs before with a good managed care regime which I assume does not discriminate against people, although all too often it does. And second, don't you think that in some ways, your industry perpetuates the stigma by telling everyone that their premiums will go up and then saying people will not accept their premiums going up if it is for mental health coverage. That is part of the stigma, isn't it, by continuing to make that argument? The Surgeon General pointed that out in his report. That is part of the stigma. First of all, you tell everybody their premiums are going to skyrocket, when none of the independent studies say that; second of all, you come here—and I looked at your testimony—and you make the argument that people in the country only support coverage for mental illness when it is not a real increase in their premiums.

That is in part because of the stigma. That is what Dr. Duckworth was saying. And you all perpetuate the stigma by the very case you make.

I do not really know how in the world—we are going to have different points of view—but I do not know how in the world you can say with a straight face that this is not a case of discrimination. For God's sake, we had Dr. Hyman, who is well-known for his work, give the analogy of someone with Parkinson's, and this is the problem, this is the treatment, and then you have someone who is struggling with schizophrenia, and there is the same kind of connection—brain disease—and you all do not provide the same coverage. If that is not discrimination, what is it? And by the way, what are the consequences for that person and his or her family?

Mr. ROSEN. I think that Dr. Hyman also said and has written that we do know more about certain biologically-based mental illnesses in terms of their diagnosis and treatment than others, and I think it is an issue of appropriately caring for those treatments and illnesses. But the same report that he talked about and the 1.4 percent, as well as the Surgeon General's report and others—and these are not our numbers—to your earlier point about us talking about premium increases and looking at the estimates that have been done by the American Psychological Association and others, they all say that costs are going to increase much more significantly in a nontightly-managed HMO setting, and I was quoting from——

Senator WELLSTONE. But that is a red herring. You have your tightly-managed managed care regimes. So why are you talking about that costs will increase if it is not there? That is not what we are talking about.

Mr. ROSEN. But it is not available everywhere in the country. Managed behavioral health networks are not widely available in rural areas. The smaller employers traditionally have not taken advantage of them because of some of the cost issues and because of some of the other issues. So it is not really fair to say that everyone in the country has the same kind of setting that will be able to hold costs to that level, and my point is that I think you have to look at the cost impact across the board.

Senator WELLSTONE. Is there a study that you can point to that is not an insurance industry study that points out that there is going to be an explosion of costs if we go to——

Mr. ROSEN. Yes, I can certainly share with you the American Psychological Association's studies, citations in the Surgeon General's studies and peer-reviewed medical journals which we have not paid for or been involved in, that have said there would be a doubling of the cost impact in a PPO or a point-of-service setting and a tripling or more of the cost impact in the fee-for-service setting. And I would be happy to share that with you, Senator.

Senator WELLSTONE. In a managed care setting?

Mr. ROSEN. In a nonmanaged care setting, the costs would be double or triple.

The CHAIRMAN. In a nonmanaged care setting.

Senator WELLSTONE. Right. And I am asking you in a managed care setting, what do they say.

Mr. ROSEN. The managed care settings have traditionally said that the cost impact will be relatively low where there are tightly-managed networks, and depending on the type of mandate.

Senator WELLSTONE. And how do you—and this is my final question—above and beyond those cost estimates, where do you factor in the cost estimate of what Dr. Hyman was talking about of the impact of this on what it costs us to treat people with physical illnesses, the costs of people not being able to work, the costs of children not being able to do well in school, the costs of what happens within families, the cost of people who take their lives—where does that figure into your cost estimate?

Mr. ROSEN. Those are all significant considerations, frankly, many of which are outside the four corners of a traditional insurance policy. They are clearly inside the four corners of something that Delta is looking at in terms of the productivity and the comprehensive care for their workers, and I think they are within the four corners of what you all need to examine in terms of the costs and benefits of this kind of legislation.

Senator WELLSTONE. I actually absolutely agree with your last point. That is what I think we should examine, and that is why I think we need to move forward in ending some of this discrimination. It would be in the public interest.

Thank you.

The CHAIRMAN. Thank you, Senator Wellstone.

I want to thank all of you for participating in this seminar. It is only the second one I have had in my time here, and it has been an exciting one, and I think maybe we—no, I will not think about holding more seminars.

Thank you all for your participation.

[Additional statements and material submitted for the record follow:]

STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. Chairman, and Members of the Committee: The American Psychological Association (APA), the largest membership association of psychologists with more than 159,000 members and affiliates engaged in the study, research, and practice of psychology, appreciates the opportunity to submit this testimony for the record regarding mental health parity. The APA strongly advocated for passage of the Mental Health Parity Act of 1996, and we are grateful to the Chairman and members of the Committee for providing a hearing to highlight the General Accounting Office (GAO) report on employer compliance with the Act and its impact on insurance claims costs.

Key GAO Finding: Employers react to parity requirements by reducing mental health benefits design features for which parity is not required.

In its report, GAO has determined that most employers are complying with the Mental Health Parity Act of 1996 (Parity Act), and that compliance has had a negligible impact on their claims costs. GAO concludes that this compliance and negligible cost impact are due to the "narrow scope" of the Act, which requires parity only for annual and lifetime dollar limits. GAO found that most employers have offset the narrow lifetime and annual dollar limit parity requirement by further restricting other mental health benefits design features, such as outpatient visit limits, inpatient days, or co-payment requirements. As GAO reports:

Although most employers' plans now have parity in dollar limits for mental health coverage, 87 percent of those that comply contain at least one other plan design feature that is more restrictive for mental health benefits than for medical and surgical benefits . . . . [M]any employers may have adopted newly restrictive mental health benefit design features since 1996 specifically to offset the more generous dollar limits they adopted as a result of the federal law. About two-thirds of these newly compliant employers changed at least one other mental health benefit design feature

to a more restrictive one compared with only about one-forth of the employers that did not change their dollar limits. (GAO/HEHS-00-95, Implementation of the Mental Health Parity Act of 1996, p. 5.)

As Congress looks to reauthorize the 1996 Parity Act before its September 30, 2001 sunset, this employer reaction to restrict other benefit design features to offset the Federal parity requirement should be a central policy consideration. Without full parity (parity coverage for all mental health benefit design features with coverage for medical/surgical benefits) employers will likely again react by restricting benefit design features for which parity is not required, causing the parity law to have "little effect on employees' access to mental health services." (GAO/HEHS-00-95 at 5.)

Only enactment of full parity legislation will ensure that employees have nondiscriminatory mental health coverage.

During debate on the passage of the 1996 Parity Act, the APA and other mental health parity advocates were hopeful that employers would forthrightly implement the lifetime and annual dollar parity requirement due to its very low impact on claims costs. GAO cites in its report that the Congressional Budget Office (CBO) had predicted that the Parity Act would increase employer premiums by a mere 0.16%.

Despite the very low cost impact associated with the 1996 lifetime and annual dollar limit parity requirement, many employers reacted by reducing other mental health coverage design features. For example, employers reduced the number of outpatient visits or inpatient days, or increased employee co-payment, deductible or out-of-pocket requirements. While the national press has characterized this employer reaction as "skirting the intent" of the federal law, the APA suggests that, however characterized, employers will react in the same manner to any new requirements imposed on them by Federal law in the future.

When employers react by reducing any part of an employee's benefit to meet a parity requirement, Congress' intent of ending unfounded discrimination against persons needing mental health services through their private coverage is thwarted. Therefore, it is evident that Congress should enact a full mental health parity law to ensure that employee access to mental health benefits truly is improved.

For this reason, the APA fully supports the "Mental Health and Substance Abuse Parity Amendments of 1999," H.R. 1515, as introduced by Representative Marge Roukema. H.R. 1515 requires full parity for all mental health benefit design features. Specifically, H.R. 1515 requires parity for outpatient visit and inpatient day limits, co-payments, deductibles, and maximum out-of-pocket requirements, in addition to parity for annual and lifetime dollar limits as currently required by through the 1996 Parity Act. An employee's mental health coverage, when offered, would have to be at parity in every respect to the employee's medical/surgical coverage. Full parity would mean that employers could not simply reduce certain design features so that employee access to mental health benefits does not improve in the aggregate.

The cost of full parity is very affordable.

The cost for employers of completely ending discrimination in mental health benefits coverage is affordable. The impact of H.R. 1515 on claims costs has not been estimated, but the bill does have a predecessor. Senators Pete V. Domenici and Paul Wellstone, sponsors of the 1996 Parity Act, had originally offered a full mental health parity provision as an amendment to the "Health Insurance Portability and Accountability Act of 1996." At that time, CBO had estimated that the Domenici-Wellstone full parity amendment would increase premiums by 4%, with employers' share of the cost increase being 1.6% of total premium costs. The Senate passed this amendment by a vote of 68 to 30 on April 18, 1996.

We know now, due to the actual experience of States that have enacted full parity laws, that the cost impact of full parity is significantly lower than 4%. For example:

Vermont enacted a full mental health parity law that became effective on January 1, 1998. As insurers filed their proposed rates for 1998, the State Division of Insurance asked them to identify the proportion of their rate increases attributable to parity. Blue Cross Blue Shield of Vermont estimated impact at zero percent for the Vermont Health Partnership (a managed care plan product), 1-3% for its comprehensive plan, and 2% for its base plan. Kaiser Permanente/CHP estimated a 2.07% increase attributable to parity.

Maryland implemented full parity in 1995. After parity was instituted, a small increase was observed in the number of inpatient admissions, but that increase was more than offset by a more significant decrease in the average length of inpatient stays. For one insurer, the proportion of the total medical premiums attributable to its mental health benefit actually decreased by 0.2%. A second managed care com-

pany with extensive experience in the State subsequently confirmed that its average expense per member per month increased by less than 1% during the first seven months after implementation of full parity. Additional data received in 1997 indicated that, after an initial increase following parity implementation, costs dropped back towards pre-parity base line levels. (Varmus, Harold M.D., U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to Congress by the National Advisory Mental Health Council, April 1997.)

Minnesota's full parity law became effective on August 1, 1995. To date, there has been no recognized cost concerns or exodus of insured plans to ERISA status in order to avoid the state's parity mandate. The State's Department of Commerce, which regulates indemnity insurance, estimated costs of 1% of total premium dollars for mental health parity. Medica, an independent consulting organization, estimated that state costs for mental health parity is 26 cents ($0.26) per member per month. (Varmus, Interim Report to Congress.)

Actual State experience and insurer cost predictions indicate that full parity coverage has a minimal impact on claims costs. The benefit gained by employees through full parity far outweighs its very low cost. With enactment of a Federal full parity law, employees are assured that their insurance coverage provides for nondiscriminatory mental health benefits, should they need these benefits.

With sunset of the 1996 Parity Act approaching, the APA looks to Congress to reauthorize the Act and provide for an end to discriminatory mental health benefits coverage in this country by enacting full parity legislation.

The 1996 Parity Act was an incremental but significant step toward ending discrimination against mental health benefits coverage. Despite indications that employers have skirted the law, the act has been a great success for which Senators Domenici and Wellstone and Representative Roukema deserve great praise. This fine and humane legislation:

This is particularly important for those employees who have faced or may suddenly face catastrophic mental illness. The Parity Act ended the typical and unjustified insurance practice of drastically capping mental health benefit lifetime and annual dollar limits. Even with the prevalent practice of restricting other mental health design features, the Parity Act ensures that employees and their families are better able to face catastrophic mental illness.

Brought the issue of discrimination against mental health benefits to national attention. Through extensive press coverage and impassioned Congressional debate, Americans became aware that their mental health benefits coverage was severely and irrationally restricted, and that families were being and could be financially and emotionally devastated by such restriction.

Acted as a catalyst by propelling many State legislatures to protect their residents by passing laws that completely ended or made significant steps towards ending discriminatory mental health benefits coverage.

Senators Domenici and Wellstone have introduced the "Mental Health Equitable Treatment Act of 1999," S. 796, to mark an important step beyond the 1996 Parity Act and toward the goal of completely ending discriminatory coverage of mental health benefits. Most importantly, S. 796 builds on the 1996 Parity Act by requiring parity for outpatient treatment visits and inpatient days for all mental disorders, in addition to lifetime and annual dollar caps. With passage of S. 796, mental health benefits plans would no longer be able to arbitrarily limit the number of outpatient visits or hospital days that employees and their families may require.

S. 796 improves upon the 1996 Parity Act in significant ways in addition to the outpatient visit and inpatient day parity requirement. The bill also increases the number of working families who will benefit from parity by lowering the employer exemption from those with 50 or fewer employees to those with 25 or fewer employees. Further, since data now demonstrates that the cost impact of parity is very low, a burdensome 1% premium impact exemption is removed. Additionally, States are permitted to continue their efforts to enact strong parity laws.

While the APA commends Senators Domenici and Wellstone for their continued fight to provide improved parity through S. 796, the GAO report intensifies our concern with a key provision of the bill. This provision identifies a narrow list of severe "biologically-based" diagnoses for which full parity will be provided (sometimes known as "severe mental illness" or "SMI" parity). Specifically, S. 796 provides for full parity for a list of severe "biologically-based" mental disorders, specified as schizophrenia, bipolar disorder, major depression, obsessive compulsive disorder and panic disorders, posttraumatic stress disorder, autism, anorexia nervosa, and atten-

tion-deficit/hyper activity disorder. Those individuals who do not have a diagnosis on this narrow list are excluded from the bill's full parity requirement.

The APA believes that it is wrong, and bad public policy, to divide persons into groups for parity coverage, based on the perceived underlying reason for their mental disorder. In reality, people suffer debilitating and serious mental health disorders, regardless of whether their diagnoses are considered "biological" in origin or not. The APA strongly supports full parity for the very serious and debilitating disorders listed in S. 796, but not at the expense of persons who may suffer equally serious and debilitating disorders that would not likely be considered as falling under the full parity umbrella.

The GAO finding that employers reacted to perceived cost implications of lifetime and annual dollar parity in the 1996 Act by further restricting other mental health benefits features intensifies our concern with the diagnosis-based full parity requirement of S. 796. If employers react in a similar manner to S. 796 when enacted, then those employees who suffer diagnoses excluded from the SMI diagnosis list may find their benefits drastically ratcheted back:

Employers will offset the perceived cost of parity for outpatient visit and inpatient day limits by increasing co-payment, deductible, and out-of-pocket requirements on those diagnoses for which full parity is not required.

Further, employers will react to the perceived cost of full parity for those with disorders on the SMI diagnosis list in the only way that they are able—by further increasing co-payment, deductible, and out-of-pocket requirements for those persons who have diagnoses not included on the list.

In essence, this is a "double whammy" on the benefits coverage for persons with diagnoses not on the SMI list, as employers attempt to offset the day and visit limit parity requirement and fund full parity for those with diagnoses on the list. Given that employers would be able to alter only the mental health benefits of a smaller pool of employees (those excluded from the full parity, diagnosis-based parity requirement), these co-payment, deductible and out-of-pocket increases could be drastic and even prohibitive for access to services.

This exacerbated impact on persons with diagnoses not on the SMI list is troubling, because these excluded diagnoses can be serious and debilitating:

Many children experience serious mental disorders that are not included in the full parity list. These include children, for example, with pervasive developmental disorders, pica (a serious eating disorder), and schizotypal personality disorder (marked by a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior). Children with these diagnoses could see a significant reduction in their mental health benefits, because they do not have a listed disorder.

Persons, particularly adolescent and young women, who suffer bulimia nervosa could see a reduction in their mental health benefit, because their diagnosis is not included on the full parity diagnosis list. Bulimia nervosa, the essential features of which are binge eating and inappropriate compensatory methods to prevent weight gain, can be disabling, life threatening or fatal.

Persons who suffer personality disorders. For example, an individual with borderline personality disorder often displays recurrent suicidal or self-mutilation behavior. These persons have diagnoses that are not included in the full parity diagnosis list.

Because the diagnosis-based list could have a devastating impact on the mental health benefits coverage of employees with diagnoses not on the list, the APA urges that the list be expanded to include all mental disorders before passage of S.796.

In fact, Congress can provide full parity for all employees, regardless of their diagnosis, for just incrementally more than it costs for providing parity for some employees included in a random list of diagnoses. In 1996, CBO estimated that parity coverage for a diagnosis-based list similar to that contained in S. 796, costs 90% of coverage for all diagnoses. CBO's cost estimate was confirmed by the Substance Abuse and Mental Health Services Administration which, in considering leading parity cost studies, stated that such studies suggest that expenses for this type of diagnosis-based list represent 89% of the increase for all mental health diagnoses due to parity.

Considering the low cost impact that parity legislation has on coverage costs, excluding individuals from full parity to reduce those costs by a mere 10% makes little sense. Rather, parity can be provided on an equitable basis for all persons with mental diagnoses with little additional impact on costs.

Conclusion

The APA urges Congress to completely end discrimination in mental health benefits coverage. All studies and experience indicate that completely banning discrimination will have a slight impact on claims costs, while employees will be assured that their mental health benefits are available, like their medical/surgical benefits, when they need them.

H.R. 1515 will completely ban discrimination, and we urge Congress to pass it. The APA also supports S. 796, but urges that it be expanded to provide full parity for all mental disorders. The GAO report demonstrates that employers will likely react to full parity for a specified list of diagnoses by drastically ratcheting back the mental health benefits associated with diagnoses not included on the list. Further, all mental disorders should be included for full parity, because we know that full parity for all diagnoses costs only slightly more than full parity for only those diagnoses listed in S. 796.

Statement of the National Alliance for the Mentally Ill

Chairman Jeffords, Senator Kennedy and members of the Committee, I am Jacqueline Shannon of San Angelo, Texas, President of the National Alliance for the Mentally Ill (NAMI). In addition to serving as NAMI's president, I am also the mother of Greg Shannon. Greg was diagnosed with schizophrenia in 1985, during his senior year in college. For the past 15 years, Greg and our entire family have struggled with his illness. We have experienced discrimination in health insurance first-hand. Our health insurance had a lifetime maximum benefit for mental illness of six thousand dollars. Greg exhausted this benefit during his first hospitalization.

For the past decade, insurance parity has remained NAMI's top legislative priority. As the nation's largest organization representing individuals with serious brain disorders and their families, 210,000 members and 1,200 affiliates, we know why a minimum standard for parity in insurance coverage is desperately needed. Our members—individuals with mental illnesses and their families—know first-hand what it means to face discrimination in health insurance.

NAMI members understand what it is like to exhaust their coverage with a single hospital stay, to be forced to pay higher deductibles and co-payments, to run through unfair limits on inpatient days and outpatient visits. What makes these discriminatory limits so unjust is that they apply only to illnesses of the brain and not to any other organ or system of the body. As I will discuss in greater detail in my testimony, NAMI believes strongly that insurance parity for the treatment of severe mental illness is at its core an issue of discrimination. We believe that mental illnesses are brain disorders, and that treatment for these illnesses are just as (if not more) effective than for other diseases. We therefore believe that health plans should not be allowed to impose limits and conditions in insurance plans that do not apply to all other diseases. In short, we are not asking for special treatment, merely the coverage that any of us expect when we need treatment.

1. Mental Illnesses Are Brain Disorders

A mental illness is, more accurately, a brain disorder; and brain disorders—like epilepsy—are biologically based medical problems. The newest medical technology can take "pictures" that show differences between brains with disorders and normal brains. In any given year, about five million American adults suffer from an acute episode of one of five serious brain disorders: schizophrenia, bipolar disorder (manic depression), severe depression, obsessive-compulsive disorder, and severe anxiety disorders. Even many of America's children—more than three million—suffer from these disorders.

Untreated, disorders of the brain profoundly disrupt a person's ability to think, feel, and relate to others and to his or her environment. Despite age-old myths and misinformation, "mental illnesses" are not caused by bad character, poor child rearing, or an individual's behavior.

Brain disorders are shrouded in stigma and discrimination. For centuries they have been misunderstood, feared, hidden, and often ignored by science. Only in the last few decades has the first real hope for people with mental illnesses surfaced, and that hope has grown from pioneering research that found both a biological basis for brain disorders and treatments that work. NAMI's efforts to combat discrimination and stigma received a major boost in December 1999 with the release of the U.S. Surgeon General's Report on Mental Health. This historic report documents the scientific evidence that treatment is effective and concludes that there is no justification for health plans to cover treatment for serious brain disorders such as schizophrenia and bipolar disorder differently from any other disease.

2. Treatment Works

As the Surgeon General documented, science has proven that severe mental illnesses are treatable. The current success rate for treating schizophrenia is 60 percent. The success rate for treating manic depression is 65 percent, and for major depression it is 80 percent. By contrast, treatment efficacy rates for interventions such as angioplasty (41 percent) and atherectomy (52 percent) are lower. Mental illnesses can now be diagnosed and treated as precisely and effectively as other medical disorders. Tragically, the stigma associated with these illnesses too often prevents people from seeking the treatment that science has proven is effective. More importantly, the fact that health insurance plans have historically imposed limitations and conditions on coverage for treatment for severe mental illness compounds this stigma.

3. Discrimination Is Wrong

Discrimination in health insurance takes many forms. The most common techniques to avoid fair coverage of mental illness treatment are: higher cost-sharing requirements for outpatient visits and prescriptions, fewer allowed inpatient days and outpatient visits, and greater annual and lifetime dollar limits. The use of these discriminatory limits and conditions has been well documented.

Numerous studies compiled prior to the enactment of parity laws (including surveys of plans by the U.S. Bureau of Labor Statistics) found that 85 percent of all plans limit inpatient care and more than 98 percent limit outpatient care. In 1991-92, the BLS Employee Benefit Survey also found that one-half of plans were restricting hospitalization to 30 to 60 days. More than 70 percent of plans were found to have limited either the dollar value of outpatient benefits or the actual number of visits. These surveys also found that arbitrary limits were often unrelated to actual treatment needs. While the federal Mental Health Parity Act (MHPA) and the 31 state parity laws are changing this discrimination, clearly a legacy of discrimination still exists in the private health insurance market.

Mr. Chairman, while these studies are persuasive, the experience of Bonnie Putnam of Florence, South Carolina more clearly articulates what NAMI members go through every day to get coverage for the treatment they need. Every year, we at NAMI receive hundreds of these personal stories that demonstrate how health insurance plans discriminate against individuals with severe mental illness and their families.

Bonnie is from Florence, South Carolina, and has been diagnosed with major depression since 1979. Even though she has worked for the same company for more than 25 years, she is on the verge of having to leave her job because she cannot afford to pay for the treatment she needs on her own, the very treatment that keeps her well enough to work. Her employer qualifies for the small-business exemption under the MHPA. South Carolina's parity law is of little benefit to Bonnie because it still allows her health plan to strictly limit coverage for outpatient medication and therapy—limits she long ago exceeded. Passage of South Carolina's law actually made things worse for Bonnie since her health plan responded by further limiting outpatient coverage. Bonnie Putnam needs true parity.

4. The 1996 Mental Health Parity Act Was an Important Step Forward

The first major step toward ending discrimination in health insurance came in 1996 when President Clinton signed the federal Mental Health Parity Act (P.L. 104-204) into law. With the leadership of Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN), this landmark law establishes a standard of parity for annual and lifetime dollar limits only. The law applies only to employers that offer mental health benefits; i.e., it does not mandate such coverage. More important, the MHPA allows many cost-shifting mechanisms, such as adjusting limits on mental illness inpatient days, prescription drugs, outpatient visits, raising co-insurance and deductibles, and modifying the definition of medical necessity.

As the General Accounting Office (GAO) noted in their testimony before this Committee, lower limits for inpatient and outpatient mental illness treatments have continued and, in some cases actually expanded to help keep costs down. However, it is important to note that the MHPA does apply to both fully insured state-regulated health plans and self-insured plans that are exempt from state laws under the Employee Retirement Income Security Act (ERISA), which are regulated by the Department of Labor. Existing state parity laws are not preempted by the MHPA (i.e., a state law requiring more comprehensive coverage is not weakened by the federal law, nor does it preclude a state from enacting stronger parity legislation, which many have). Other critical limitations in the MHPA include a small-business exemption (for firms with 50 or fewer employees) and an increased cost exemption for em-

ployers that can demonstrate a one percent or more rise in costs due to parity implementation will be allowed to exempt themselves from the law.

NAMI is encouraged by the GAO findings presented at this hearing that 86 percent of surveyed health plans are complying with the MHPA. While it is alarming that 14 percent of the surveyed plans are not in compliance, we view this as a lack of effort on the part of state insurance commissioners, the Health Care Financing Administration (HCFA), and the Pension and Welfare Benefits Administration (PWBA) to educate employers about the new law. Likewise, as the GAO noted, compliance is based largely on a complaint-driven process, that places responsibility on aggrieved plan participants to come forward—which often fails because of the stigma associated with mental illness. To ensure greater compliance with the MHPA and all future federal parity efforts, NAMI urges Congress to push HCFA and PWBA to do more to educate employers and health plans about their responsibilities under the law and to randomly audit representative samples of large, medium, and small employers for compliance.

Mr. Chairman, it is interesting to note that while the opponents of the MHPA attempted to vastly expand the scope of this increased cost exemption during regulatory implementation of the MHPA, relatively few employers have used it. NAMI believes that this is due in part to accountability measures included in the regulations (by retrospective examination of claims data, disclosure to employees when a firm seeks an exemption, etc.). However, the fact that fewer than ten employers have sought the one- percent cost exemption is more than likely due to the fact that parity is affordable and costs simply have not gone up because of it.

5. 31 States and FEHBP Have Adopted Parity

As is often the case, states have taken the lead ahead of Congress in ending insurance discrimination. The original idea behind parity was modeled on legislation in the 1960s that prohibited cancer exclusions in insurance coverage. Mental health parity was first successful with state employees in Texas, then in Maine, New Hampshire, Rhode Island, and Maryland. By the early 1990s, parity laws had been passed in six states. Although these laws do not apply to ERISA self-insured companies, they give employees some protection and they serve to statistically validate the fact that parity is affordable. After enactment of the federal MHPA in 1996, we saw the passage of nine more state parity laws in 1997 and seven (unfortunately three were vetoed) in 1998. In 1999, 11 more states enacted parity laws, bringing the total number of states with such laws to 28. With the addition of California, now more than half the population lives in States that require non-discriminatory coverage.

Already in 2000, Kentucky, Massachusetts, and New Mexico have passed parity laws, which brings the total to 31 states. Clearly, the trend to pass state parity legislation is picking up momentum. Even today, NAMI affiliates are continuing to seek out legislative leaders to sponsor State parity bills of all types with the ultimate goal of ending all insurance discrimination against those who suffer from mental illnesses. NAMI will continue to provide documentation of the experiences of the states that passed parity laws in the early 1990s and other evidence of the affordability of parity and the effectiveness of treatment. NAMI will seek coverage equal to that of other medical conditions covered in each policy written, and we will not turn away from this effort until the discrimination has ceased.

Even though Congress has not acted to expand the modest protections in the Mental Health Parity Act since its passage nearly four years ago, the Clinton Administration has moved to expand the scope of parity. In June of 1999, as part of the historic White House Conference on Mental Health, the President announced that the Federal Employees Health Benefits Program (FEHBP) would require parity beginning in January 2001. FEHBP is the largest health insurance program in the nation, covering 9.5 million federal employees, retirees, and their families.

6. Parity Is Affordable

One of the principal lessons learned from the experience in the states that have enacted parity laws—as well as from preliminary estimates by the Office of Personnel Management (OPM) for FEHBP—is that parity is unquestionably affordable. This affordability is especially evident under the laws that focus the parity requirement on a categorical list of severe diagnoses.

As has been made clear at this hearing, the cost of paying for health insurance parity for mental illness unfortunately remains a hotly debated issue. This is disturbing to us at NAMI since overwhelming evidence from multiple studies controversy demonstrates the minimal cost impact resulting from parity. As the GAO found in its report on MHPA implementation, only 3 percent of surveyed plan administrators found that their insurance costs went up as a result of compliance. For the record, I would like to briefly summarize just a few of these studies—most of

them from independent sources with no stake in the policy debate over parity—that have provided data in recent years:

Background Report: Effects of the Mental Health Parity Act of 1996 (March 30, 1999)—Issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), results of this national survey showed that 86 percent of employers who made changes in health plans to comply with the 1996 federal law did not make any compensatory reductions in other benefits because the cost of compliance was minimal or nonexistent.

Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access & Quality (July 15, 1998)—The second in a series of reports to Congress issued by the National Advisory Mental Health Council found that full parity costs less than one percent of annual healthcare costs. When implemented in conjunction with managed care, parity can reduce costs by 30 to 50 percent.

Rand Corporation Study (November 12, 1997)—This study found that equalizing annual limits (typically $25,000)—a key provision of the Mental Health Parity Act of 1996—will increase costs by only about $1 per employee per year under managed care. An even more comprehensive change required by some state laws (i.e., removing limits on inpatient days and outpatient visits) will increase costs by less then $7 per enrollee per year. The main beneficiaries of parity were found to be families with children who, under current conditions, are more likely than adult users to quickly exceed their annual benefit limits and go uninsured for the remainder of the year.

Mercer Study (October 23, 1997) -The findings of this study indicated that 85 percent of American companies are either in compliance with the federal law or plan to comply with the Mental Health Parity Act of 1996 by January 1, 1998. Seven out of ten of those same employers agree that mental health parity is a reasonable national policy goal and that parity is important to their employees.

National Advisory Mental Health Council's Interim Report on Parity Costs (April 29, 1997)—This report found that the introduction of parity in combination with managed care results in, at worst, very modest cost increases. In fact, lowered costs and lower premiums were reported within the first year of parity. Maryland reported a 0.2 percent decrease after the implementation of full parity at the state level. Rhode Island reported a less than 1 percent (0.33 percent) increase of total plan costs under state parity. Texas experienced a 47.9 percent decrease in costs for state employees enrolled in its managed care plan under parity.

Lewin Study (April 8, 1997)—In this survey of New Hampshire insurance providers, no-cost increases were reported as a result of a state law requiring health insurance parity for severe mental illnesses.

7. Let's Finish the Job—S 796

As I noted above, the combined effect of the MHPA, the 31 state laws, and parity for FEHBP participants, while substantial and historic, still leave too many individuals with mental illness behind. Parity has become a reality in our country, but discrimination persists—particularly for individuals in ERISA self-insured plans and in cost-sharing requirements that apply only to mental illness treatment.

NAMI believes strongly that S. 796, the Mental Health Equitable Treatment Act, is needed to address these gaps in parity and finish the job of ending discrimination for persons living with the most severe and disabling forms of mental illness. NAMI's consumer and family membership is extremely grateful for the leadership of Senators Domenici and Wellstone in seeking to once and for all end discrimination.

The Mental Health Equitable Treatment Act requires that limitations on the coverage of benefits for "severe biologically based mental illnesses" may not be imposed unless comparable limitations are imposed on medical and surgical benefits. This provision provides full insurance parity for treatment for people with severe mental illnesses and effectively removes all inequitable limits on co-pays, deductibles, inpatient days, and outpatient visits.

S. 796 targets specific adult and childhood mental illnesses and defines the term "severe biologically based mental illnesses" as illnesses determined by medical science in conjunction with the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) to be severe and biologically-based. These illnesses are listed in the bill as: schizophrenia, bipolar disorder (manic depression), major depression, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, autism and other severe and disabling mental disorders such as anorexia nervosa and attention deficit/hyperactivity disorder.

S. 796 also prohibits unequal limits on the number of covered inpatient days and outpatient visits for people seeking treatment for all mental illnesses. Under this provision, the number of covered impatient days and outpatient visits for mental ill-

nesses must be equal with covered medical/surgical inpatient days and outpatient visits.

Other key features of S. 796 include a small-business exemption for firms with 25 or fewer employees. This change from the 1996 MHPA (its small-employer exemption is 50 or fewer workers) will result in an additional 15 million workers and their families being covered by parity. S. 796 also eliminates the existing expiration provision in the MHPA that sunsets its requirements on October 1, 2001. In addition, S. 796 eliminates the "one percent" cost exemption in the MHPA mentioned above.

S. 796 is core to NAMI's vision of ensuring that the next generation of individuals with mental illness and their families will not have to live out their lives on disability or in public institutions, unable to get the very care that would give them back productive lives. Insurance discrimination enforces the invalid message that mental illnesses are "untreatable" and "hopeless." As I have noted above, parity is both affordable and cost-effective. With parity as envisioned in S. 796, businesses in fact stand to gain: from reduced absenteeism, reduced healthcare costs for physical ailments related to mental illnesses, increased employee morale, and increased productivity overall.

Mr. Chairman, I would like to make one additional point about S. 796 as it relates to a very important new law that Congress enacted last year—the Ticket to Work and Work Incentives Improvement Act (P.L. 106-170). First, on behalf of NAMI's consumer and family membership I would like to thank you, Chairman Jeffords, and you, Senator Kennedy, for the outstanding bipartisan leadership you showed in moving this legislation through the Senate last year by wide bipartisan margins. We are extremely grateful for your efforts on the critical issue of extending health insurance coverage for adults with severe disabilities who can, and in fact, want to work. In the coming years, thousands of adults with severe metal illnesses will be able to leave the Social Security rolls for the workforce, without fear of losing coverage under Medicare and Medicaid.

How does parity relate to TWWIIA? Just as with the "pre-disability" Medicaid state demonstration in the new law, NAMI believes that parity is integral to establishing state and federal policies that prevent people from ever having to quit their job and go into poverty to get the medical care they need. If working adults with severe mental illnesses have adequate and non-discriminatory health care coverage, they will be able to access the treatment they need earlier in the course of their illness and perhaps need less treatment over their lifetimes. Likewise parity will ensure that they can retain access to coverage for the treatment they need to maintain functioning and stay in a job. For NAMI, parity as envisioned in S. 796 is an extension of TWWIIA and its goal of shifting disability in our nation to foster, rather than inhibit, employment, productivity and independence.

Finally, Chairman Jeffords, I would like to respond on the record to the observations made by Ken Libertoff, Ph.D., of the Vermont Mental Health Coalition earlier in this hearing. In his testimony, Dr. Libertoff characterized S. 796 as inadequate for meeting the needs of children and adolescents with mental illnesses. He also stated that this important legislation is a "step sideways" in ending insurance discrimination. NAMI would like to take issue with his unfair and inaccurate observations about S. 796.

First, it should be noted that S. 796 includes full parity for every major severe mental disorder in children and adolescents, including early onset bipolar disorder, major depression, obsessive compulsive-disorder, panic disorder, autism, and other severe and disabling mental disorders such as anorexia nervosa and attention-deficit/hyperactivity disorder. In addition, the bill includes full parity for adolescents experiencing the onset of schizophrenia—a process that can commonly exhaust coverage for many families with a single hospitalization. More important, this legislation contains protections that will permit adding to the list of diagnoses for which full parity is required as medical science accumulates more evidence about which childhood disorders are biologically based (thereby to be covered under full parity). Thus, the provisions in S. 796 will keep pace with scientific advances in knowledge about child and adolescent disorders and their treatments. NAMI strongly supports S. 796 as a major step forward for children and adolescents with mental illnesses and their families.

Finally, as a response to the allegation that S. 796 is a "step sideways," NAMI notes how clear it is quickly becoming that, in seeking to end discrimination, Congress and the states have an obligation to first address the needs of those most profoundly and directly affected by inadequate coverage. Given the broad scope of mental health disorders as defined by the DSM IV, NAMI emphasizes that it is the severe diagnoses listed in this legislation as those to be included in the full parity requirement that cause people to exhaust the coverage in their health plans. It is

these diagnoses that result in families having to borrow, go into debt, take out second mortgages, file for bankruptcy, quit jobs and relinquish custody of their children to qualify for public benefits that—when all else fails—give them access to treatment.

In NAMI's view, it is these families and individuals that have historically shouldered the burden of severe mental illness in our country. In NAMI's view, it is these families and individuals that Congress and the President should place foremost in their priorities while moving forward in the debate over mental illness parity. Clearly, S. 796 is a profound, life-saving, and historic step for these families and individuals touched by mental illness.

Conclusion

Chairman Jeffords and Senator Kennedy, thank you for the opportunity to share NAMI's views on this important issue. We look forward to working with you and all members of this Committee to ensure that the Senate acts on S. 796 this year.

STATEMENT OF THE NATIONAL DEPRESSIVE AND MANIC-DEPRESSIVE ASSOCIATION

The National Depressive and Manic-Depressive Association (National DMDA) is pleased to have this opportunity to submit written testimony supporting parity for mental health.

With more than 300 support groups in nearly every state, National DMDA is the nation's largest patient-directed, illness-specific organization committed to advocating for research toward the elimination of mood disorders; educating patients, professionals and the public about the nature and management of depression and manic-depression (also known as bi-polar disorder) as treatable medical diseases; fostering self-help; eliminating discrimination and stigma; and improving access to care. National DMDA was founded in 1986 and is headquartered in Chicago, Illinois. A distinguished scientific advisory board of 65 preeminent researchers and clinicians in the field of mood disorders reviews all materials published by National DMDA and provides critical and timely advice on important research opportunities and treatment breakthroughs.

THE IMPACT OF DEPRESSIVE ILLNESS

More than 20 million American adults suffer from unipolar or major depression every year. At least 2.3 million people suffer from manic-depression or bipolar disorder. Women are more than twice as likely as men to experience major depression. Two out of three people with mood disorders do not get proper treatment because their symptoms are not recognized, are misdiagnosed or, due to the stigma associated with mental illness, are blamed on personal weakness. Depression is the leading cause of suicide in America. There are more deaths from suicide in the United States today than from homicide.

According to a recent study by the World Health Organization (WHO), the World Bank, and the Harvard School of Public Health, unipolar major depression is the leading cause of disability in the world today and bipolar disorder is the seventh-ranked cause of disability. The economic cost of depressive illness in the United States is estimated to be $44 billion per year in direct and indirect costs including absenteesim, mortality and lost productivity. We cannot continue to ignore the seriousness of mental illness.

THE STIGMA OF MENTAL ILLNESS

Depressive and manic-depressive disorders are treatable medical illnesses, no different than heart disease or diabetes, if diagnosis and treatment is received. More than 80 percent of people suffering from depression respond favorably to treatment. Yet only one in 10 receive appropriate treatment in the United States today. Tragically, individuals untreated or undertreated for major depression have a suicide rate in excess of 15 percent. For those with bipolar disorder, the suicide rate is in excess of 20 percent.

One of the biggest obstacles to expanding access to services is the historical stigma surrounding mental illness and its treatment. An individual experiencing symptoms of depression, for example, may not feel comfortable talking to family members or a doctor about it out of fear of being perceived as weak. The stigma surrounding mental illness is powerful. It prevents patients from getting treatment. It can cause death.

REDUCING STIGMA THROUGH PARITY

One way this stigma is exemplified is by arbitrary and unfair limits placed on access to mental health services by private health insurance plans. There is no scientific, financial or ethical justification for the artificial distinction made between physical and mental illness in insurance coverage. Thirty-one states formally recognize this fact by requiring equal insurance coverage for physical and mental illness.

Insurance parity is proven to be cost-effective. According to a July 1998 report of the National Advisory Mental Health Council, managed care systems that implement parity experience a less-than-one-percent increase in total health care costs a year. Systems that jointly implement managed care and parity witness a substantial reduction in total mental health costs, up to 30-to-50 percent.

Insurance coverage is not the only issue with regard to parity. Another barrier is access to appropriate care. In HMOs and other managed care systems, for example, patients must first visit a general practitioner. Financial incentives may be in place to discourage the referral of patients with depression or manic depression to psychiatrists for appropriate care. Instead, a large number of patients are treated by general practitioners who frequently lack the experience to diagnose complex illnesses such as depression and manic depression. In many cases they also lack the medical training necessary to treat the illnesses.

LEGISLATIVE REMEDIES

Given this current status of mental health insurance coverage, legislation such as the Mental Health Equitable Treatment Act of 1999 is long overdue. The 1996 Mental Health Care Parity Act was an important first step toward eliminating the distinctions made between physical and mental illnesses. We commend Senators Domenici and Wellstone on their commitment to taking it to the next level and moving toward full parity with the introduction of the Mental Health Equitable Treatment Act of 1999. Requiring treatments for mental illnesses to be reimbursed at the same level as treatments for physical illnesses is critical to reducing the number of patients who remain untreated or undertreated—and to reducing the stigma surrounding mental illness. Prohibiting limits on the number of inpatient days and outpatient visits for mental health treatment is also crucial.

As more and more people come to understand that depressive and manic-depressive disorders are medical problems, not character flaws, and that they can be treated, we can make significant reductions in both the human and economic costs of these illnesses.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American Occupational Therapy Association (AOTA) supports legislation to correct the disparity in coverage between physical illnesses and mental illnesses in many health insurance programs and products. The Senate Health, Education, Labor, and Pensions (HELP) Committee's hearing is a positive step toward assuring Congressional action on mental health parity in the 106'h Congress. AOTA believes action is needed to promote full coverage for mental health services for patients whose lives are affected by restrictive and limiting policies of health insurance and care providers. While many gains have been made with previous legislation, the HELP Committee's hearing recognizes that prejudice in regard to access to treatment must continue to be challenged.

AOTA recognizes the leadership of HELP Committee Chairman Jim Jeffords, Senator Pete V. Domenici, and Senator Paul Wellstone in efforts to address this critical area of needed legislation. Such legislation should assure that services provided are adequate, appropriate and provided by qualified professionals.

AOTA is a professional association that represents more than 50,000 occupational therapists and occupational therapy assistants across the country.

OCCUPATIONAL THERAPY AND MENTAL HEALTH

Occupational therapy has its roots in the mental health field. Occupational therapy is a health and rehabilitation service that uses "purposeful activities," or occupations to achieve health and optimal function. Occupational therapy has grown to be a dynamic, multifaceted health and rehabilitation profession but continues to have a significant role in mental illness. Its practitioners work in many settings and with a variety of individuals in mental health: occupational therapists work with children with severe emotional and behavioral problems to help them develop into healthy adults; they work with adolescents who have drug abuse or other problems such as homelessness; they work in "club house" and other community treatment

models to help adults with significant disabilities such as schizophrenia to function in daily life.

Occupational therapy assists in the recovery process by addressing functional skills and symptom management. Occupational therapy practitioners provide services to patients whose mental illness interferes with performance of every day living activities such as working, community mobility, and caring for self and family. When a person, due to a mental impairment, is unable to perform an "occupation" such as getting ready for work or school, the occupational therapist adapts the environment and teaches compensatory techniques to accommodate the individual's skill deficits. Occupational therapy's approach includes identifying characteristics of the activity, including physical, sensory, perceptual, cognitive, psychosocial, cultural, and other aspects. It includes an analysis of the underlying components causing performance deficits and considers, along with the diagnosis of mental illness, the contextual factors affecting the individual's ability to perform their desired activities. These can include environment, age, health, culture, safety, and available supports.

Occupational therapists bring a unique perspective to mental health care. The mental health team benefits from the information gained using a variety of functional assessment methods, to determine the individual's desire, needs and limitations in functioning in daily life and their chosen activities, or "occupations." Occupational therapists use performance evaluation, which involves observation and analysis of an individual's ability to perform daily tasks in relation to environmental demands. This approach can be instrumental in enabling an individual with severe mental illness to succeed in community life and proceed with the process of recovery. Occupational therapists review components of function such as:

- Sensorimotor skills of balance, sensory processing, coordination and endurance;
- Cognitive skills such as attention, organization sequencing, problem-solving and generalization;
- Psychosocial skills such as self-control, self-expression and interpersonal skills.

Occupational therapy's perspective can identify underlying problems of sensorimotor issues or cognition, which may in fact be contributing to noncompliant behavior, lack of motivation, and inability to cope with daily life activities.

Occupational therapy is a service reimbursed through many sources including Medicare, Medicaid, private insurance, vocational rehabilitation, worker's compensation, and special education programs.

Issues in Parity Legislation

AOTA expresses support for legislation to assure parity between services provided for physical illnesses and those for mental illnesses. Research is continually reinforcing the importance of treatment for mental illnesses. However, access to services remains constrained by issues including stigma, cost and access to qualified providers. Parity legislation would assure that health care coverage plans would offer equal visits, equal choice in type of service, and equity in areas such as annual limits.

AOTA also expresses concern that any parity legislation must assure that the services that are offered to meet the parity requirements are services that are adequate and appropriate to meet the needs of individuals with varying conditions. This would require, in part, that health plans must assure that services for mental illnesses are provided by qualified professionals, licensed or regulated under state law. Quality and effectiveness would be better served by the use of appropriate providers for the services.

Parity legislation is needed to assure that people with mental illnesses can surmount the stigma in society—which is perpetuated by the discrimination in health insurance benefits—and receive the services they need. AOTA applauds the HELP Committee in its efforts to promote full coverage for needed mental health services for patients whose lives are affected by restrictive and limiting policies of health insurance and care providers. Recent testimony and reports indicate that some gains have been made with previous legislation. AOTA urges the Committee, the Senate and the House of Representatives to recognize that prejudice in regard to access to treatment must continue to be challenged and corrected.

Occupational Therapy and Mental Health

Occupational therapy has its roots in mental health. In the early part of this century, occupational therapy developed as a profession using principles of physiology, psychology, neurology and other sciences but was first a mental health profession. Many occupational therapists worked with soldiers with "shell shock," or post-traumatic stress syndrome, using purposeful activities to enable them to regain ability to function in life.

Occupational therapy has grown to be a dynamic, multifaceted health and rehabilitation profession but continues to have a significant role in mental illness. Today, occupational therapy practitioners work in mental health in community programs, in residential treatment programs, with those with severe mental illnesses such as schizophrenia and with children who are experiencing behavioral problems in school.

Occupational therapy assists in the recovery process by addressing functional skills and symptom management. Occupational therapy provide services to patients whose mental illness interferes with performance of every day living activities such as working, community mobility, and caring for self and family. When a person, due to a mental impairment, is unable to perform an "occupation" such as getting ready for work or school, the occupational therapist adapts the environment and teaches compensatory techniques to accommodate the individual's skill deficits. Occupational therapy's approach includes identifying characteristics of the activity, including physical, sensory, perceptual, cognitive, psychosocial, cultural, and other aspects. Similar approaches are used to manage symptoms in order to allow individuals to complete their workplace, self-care or other activities more independently and successfully.

Occupational therapy begins with the individual, their family, their desires and goals, and their environment. It includes an analysis of the underlying components causing performance deficits and considers, along with the diagnosis of mental illness, the contextual factors affecting the individual's ability to perform their desired activities. These can include environment, age, health, culture, safety, and available supports.

Many occupational therapy practitioners are moving into unique areas of mental health practice:

- Working with **the homeless in a program for adolescents** who have mental health problems as well as one for those **homeless with multiple issues** (mental health/HIV infection/drug abuse/mental health problems;
- Enabling **children with disabilities to live at home** rather than in institutions through provision of comprehensive supports in a **"wrap around"** program;
- Promoting **functional living skills including work** with adults with severe mental illnesses, including schizophrenia, in community based programs such as "clubhouse" programs;
- **Preventing mental health problems by working to enable full social competence of children** so that they may learn essential elements of self-understanding, function, and self-protection to enable them to meet the challenges of growth, development and adulthood;
- Addressing **the mental health needs of elderly** nursing home patients including depression, loss of identity with changing life roles, and mental health issues accompanying Parkinson's disease, stroke and other physical conditions.

Occupational therapists bring a unique perspective. The mental health team benefits from the information gained using a variety of functional assessment methods, to determine the individual's desire, needs and limitations in functioning in daily life and their chosen activities, or "occupations." Occupational therapists use performance evaluation, which involves observation and analysis of an individual's ability to perform daily tasks in relation to environmental demands. This approach can be instrumental in enabling an individual with severe mental illness to succeed in community life and proceeding with the process of recovery.

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Occupational therapy is a service reimbursed through many sources including Medicare, Medicaid, private insurance, vocational rehabilitation, worker's compensation, and special education programs.

Suggestions for Areas of Conference Program

1. EARLY CHILDHOOD: Session on occupational therapy and other interventions to promote social competence and mental health in young children including children with developmental disabilities or delays.

2. HOMELESSNESS: Session on programs, including occupational therapy services, for young people with mental illnesses or other psychological problems who are homeless.

3. WRAPAROUND PROGRAMS: Session on programs that provide "wraparound" services to children and families to promote community participation, including reintegration following institutional placement.

The CHAIRMAN. The seminar is now adjourned.

[Whereupon, at 12:21 p.m., the committee seminar was adjourned.]

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